



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Medical History

Please indicate the appropriate answer if you have / had any of the following

#### Heart / Cardiovascular

1. \_\_\_ Yes \_\_\_ No: Rheumatic Heart Disease / heart murmur
2. \_\_\_ Yes \_\_\_ No: Damaged or Artificial heart valve
3. \_\_\_ Yes \_\_\_ No: Mitral valve prolapse
4. \_\_\_ Yes \_\_\_ No: Congenital heart disease
5. \_\_\_ Yes \_\_\_ No: High blood pressure
6. \_\_\_ Yes \_\_\_ No: Low blood pressure
7. \_\_\_ Yes \_\_\_ No: Arteriosclerosis / High cholesterol
8. \_\_\_ Yes \_\_\_ No: Chest pain after exertion
9. \_\_\_ Yes \_\_\_ No: Shortness of breath after mild exercise
10. \_\_\_ Yes \_\_\_ No: Heart attack
11. \_\_\_ Yes \_\_\_ No: bypass surgery
12. \_\_\_ Yes \_\_\_ No: Heart pace maker/Irregular or rapid Heart rate
13. \_\_\_ Yes \_\_\_ No: Stroke
14. \_\_\_ Yes \_\_\_ No: Do your ankles swell?
15. \_\_\_ Yes \_\_\_ No: Do you use extra pillows to sleep?
16. \_\_\_ Yes \_\_\_ No: Other heart problems?

#### Allergies To:

1. \_\_\_ Yes \_\_\_ No: Penicillin
2. \_\_\_ Yes \_\_\_ No: Sulfa
3. \_\_\_ Yes \_\_\_ No: Aspirin / Codeine / Other pain medications \_\_\_\_\_
4. \_\_\_ Yes \_\_\_ No: Iodine
5. \_\_\_ Yes \_\_\_ No: Sedatives / Sleeping Pills / Barbiturates
6. \_\_\_ Yes \_\_\_ No: Local Anesthetics \_\_\_\_\_
7. \_\_\_ Yes \_\_\_ No: Latex
8. \_\_\_ Yes \_\_\_ No: Metals \_\_\_\_\_
9. Other Medications: - \_\_\_\_\_  
\_\_\_\_\_

#### Breathing / Lungs / Sinuses

1. \_\_\_ Yes \_\_\_ No: Shortness of breath / Breathing problem
2. \_\_\_ Yes \_\_\_ No: Asthma / Hay fever
3. \_\_\_ Yes \_\_\_ No: Emphysema / COPD
4. \_\_\_ Yes \_\_\_ No: Tuberculosis / Persistent cough or cold
5. \_\_\_ Yes \_\_\_ No: Sinus problem / Sinusitis /Nasal problem
6. \_\_\_ Yes \_\_\_ No: Do you smoke?

#### Central Nervous System

1. \_\_\_ Yes \_\_\_ No: Epilepsy
2. \_\_\_ Yes \_\_\_ No: Fainting Spell
3. \_\_\_ Yes \_\_\_ No: Seizures
4. \_\_\_ Yes \_\_\_ No: Emotional disturbances

#### Blood Conditions

1. \_\_\_ Yes \_\_\_ No: Anemia
2. \_\_\_ Yes \_\_\_ No: Leukemia
3. \_\_\_ Yes \_\_\_ No: Sickle Cell trait / Disease
4. \_\_\_ Yes \_\_\_ No: Hemophilia/Excessive bleeding/Bruise easily
5. \_\_\_ Yes \_\_\_ No: Blood transfusion
6. \_\_\_ Yes \_\_\_ No: HIV positive
7. \_\_\_ Yes \_\_\_ No: Family history of blood disorder

#### Endocrine System

1. \_\_\_ Yes \_\_\_ No: Do you have Diabetes?
2. \_\_\_ Yes \_\_\_ No: Does anyone in your family have Diabetes?
3. \_\_\_ Yes \_\_\_ No: Hypothyroidism / Hyperthyroidism
4. \_\_\_ Yes \_\_\_ No: Are you thirsty very often / Have a dry mouth?

#### Digestive System

1. \_\_\_ Yes \_\_\_ No: Stomach ulcers
2. \_\_\_ Yes \_\_\_ No: Hepatitis
3. \_\_\_ Yes \_\_\_ No: Jaundice
4. \_\_\_ Yes \_\_\_ No: Liver Disease

#### Bones and Joints

1. \_\_\_ Yes \_\_\_ No: Arthritis
2. \_\_\_ Yes \_\_\_ No: Inflammatory Rheumatism
3. \_\_\_ Yes \_\_\_ No: Bone infection
4. \_\_\_ Yes \_\_\_ No: Artificial joints
5. \_\_\_ Yes \_\_\_ No: Osteoporosis

#### Other

1. \_\_\_ Yes \_\_\_ No: Kidney trouble
2. \_\_\_ Yes \_\_\_ No: Dialysis
3. \_\_\_ Yes \_\_\_ No: Syphilis / Gonorrhea
4. \_\_\_ Yes \_\_\_ No: Lupus / Auto Immune Disease
5. \_\_\_ Yes \_\_\_ No: Do you have glaucoma?  
If yes, what type: Narrow angle:\_\_\_\_\_ Open angle:\_\_\_\_\_

#### Neoplasm

1. \_\_\_ Yes \_\_\_ No: Cancer / Tumor  
If yes, what kind?  
\_\_\_\_\_
2. \_\_\_ Yes \_\_\_ No: Chemotherapy  
If yes, what medications?  
\_\_\_\_\_
3. \_\_\_ Yes \_\_\_ No: Radiation Therapy  
If yes, area of radiation: \_\_\_\_\_

Medical History (cont.)

**General**

- Yes  No: Do you have or have you ever had any condition, disease, or problem NOT listed above that you think I should know about?  
If yes, explain:  
\_\_\_\_\_
- Yes  No: Do you Drink Alcohol?  
If yes, how much and how often?  
\_\_\_\_\_
- Yes  No: Do you smoke?  
If yes, how much?  
\_\_\_\_\_
- Yes  No: Do you use oral tobacco?  
If yes, how much and how often?  
\_\_\_\_\_
- Yes  No: Do you use any recreational drugs?  
If yes, what and how often?  
\_\_\_\_\_

**Women Only**

- Yes  No: Are you pregnant or suspect being pregnant?
- Yes  No: Are you nursing?
- Yes  No: Are you taking any oral contraception or hormonal therapy?
- Yes  No: Osteoporosis

**Man only:**

- Yes  No: Do you use any medication for Erectile Dysfunction?  
If yes, what and when was the last time you used it?  
\_\_\_\_\_

**Dentist's Notes**

**VITAL SIGNS**

B.P.: \_\_\_\_\_ H.R. : \_\_\_\_\_ Resp Rate : \_\_\_\_\_

Weight: \_\_\_\_\_ Temp : \_\_\_\_\_

**AUTHORIZATION**

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all the questions to the best of my knowledge. I will not hold DR. RAJIV PATEL or any other member of his staff responsible for any error or omissions that I might have made in the completion of this form. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify Dr. Patel of any change in my health or medications. I also consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated. I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock.

\_\_\_\_\_  
Patient's/guardian's signature

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Dental History

1. What is your chief dental complaint? \_\_\_\_\_
2. Are you experiencing any discomfort or pain?  Yes  No
3. How often do you have your dental exam? \_\_\_\_\_
4. When was your last dental visit \_\_\_\_\_
5. Do you feel nervous about dental treatment?  Yes  No
6. Have you had any serious trouble associated with any previous dental treatment?  Yes  No
7. Are you satisfied with the appearance of your teeth?  Yes  No  
If NO what would you like to have changed about the way your teeth looks? \_\_\_\_\_
8. Are your teeth sensitive to hot or cold?  Yes  No
9. Do your gums bleed when you brush?  Yes  No
10. Have you noticed any bad odor or bad taste?  Yes  No
11. Do you get frequent cold sores, blisters etc.?  Yes  No
12. Do you clinch or grind your teeth while awake or asleep?  Yes  No
13. Do you have tired jaw, especially mornings?  Yes  No
14. Are you aware of jaw joint sound?  Yes  No
15. Did you ever have jaw joint sound?  Yes  No
16. Do you ever have pain or soreness in front of your ears?  Yes  No
17. Do you have ear pain?  Yes  No
18. Do you wake up with your jaws sore or tired?  Yes  No
19. Do you ever have difficulty opening your jaw widely?  Yes  No
20. Do you avoid eating certain foods because of pain or discomfort?  Yes  No
21. Do you snore?  Yes  No
22. Has anyone reported that you choke or gasp for air while sleeping?  Yes  No
23. Do you wake up refreshed?  Yes  No

#### Have you had or experienced:

- |   |   |
|---|---|
| 1. <input type="checkbox"/> Yes <input type="checkbox"/> No : Orthodontic treatment         | 2. <input type="checkbox"/> Yes <input type="checkbox"/> No : Bite adjustment           |
| 3. <input type="checkbox"/> Yes <input type="checkbox"/> No : Oral surgery                  | 4. <input type="checkbox"/> Yes <input type="checkbox"/> No : Bite plate/mouth guard    |
| 5. <input type="checkbox"/> Yes <input type="checkbox"/> No : Periodontal Treatment         | 6. <input type="checkbox"/> Yes <input type="checkbox"/> No : Injury to head/mouth      |
| 7. <input type="checkbox"/> Yes <input type="checkbox"/> No : Clicking/popping of jaw       | 8. <input type="checkbox"/> Yes <input type="checkbox"/> No : Difficulty chewing        |
| 9. <input type="checkbox"/> Yes <input type="checkbox"/> No : Difficulty opening or closing | 10. <input type="checkbox"/> Yes <input type="checkbox"/> No : Sore mouth/neck/shoulder |

Do you wear dentures now?  Yes  No

Upper complete  Lower Complete  Upper Partial  Lower Partial

Since how long? \_\_\_\_\_

How old is this denture? Upper \_\_\_\_\_ Lower \_\_\_\_\_

Was it an immediate denture?  Yes  No

Do you like the **shape**?  Yes  No **Size**?  Yes  No **Color**?  Yes  No

Other Comments: \_\_\_\_\_

What's most important to you in your dental health? \_\_\_\_\_

What is most important to you when choosing a dentist? \_\_\_\_\_

\_\_\_\_\_  
Patient's/guardian's signature

\_\_\_\_\_  
Date