MEDICAL/DENTAL HISTORY for _____

DR. RUTH ROJAS
Prosthodontics & Cosmetic Dentistry

Welcome! So that we may provide you with the best possible care please complete both of these medical and dental history forms. In the following questions circle yes or no. Your answers are for our records only and will be considered confidential. THESE FACTS HAVE DIRECT BEARING ON

YOUR MEDICAL HEALTH

1. Are you in good general health? ..... YES NO
2. Has there been any change in your health within the past year ..... YES NO
3. Your last physical examination was on (approximate date) _____
4. Have you lost or gained more than ten (10) pounds in the past year? ..... YES NO
5. Are you now under the care of a physician? ..... YES NO
   If so, what is the condition(s) being treated? _____
6. The name, address and phone # of your physician _____
   _____
   Pharmacy Name_____ Phone#(___) _____
7. Are you taking any drug or medicine? ..... YES NO
   If so, what? _____
   _____
   _____

8. Are you taking any of the following:
   a. Antibiotics ..... YES NO
   b. Anticoagulants (blood thinners) ..... YES NO
   c. Medicine for high blood pressure ..... YES NO
   d. Cortisone or steroids ..... YES NO
   e. Tranquilizers ..... YES NO
   f. Antihistamines ..... YES NO
   g. Aspirin (Ecotrin) ..... YES NO
   h. Insulin or diabetes drug ..... YES NO
   i. Digitalis or drug for heart trouble ..... YES NO
   j. Nitroglycerin ..... YES NO
   k. Oral contraceptive or other hormonal therapy (estrogen) ..... YES NO
   l. Vitamins or other nutritional supplements ..... YES NO

9. Are you allergic or have you reacted adversely to:
   a. Local anesthetics (lidocaine, novocaine) ..... YES NO
   b. Penicillin or other antibiotics ..... YES NO
   c. Sulfa drugs ..... YES NO
   d. Barbiturates, sedatives, or sleeping pills ..... YES NO
   e. Aspirin or ibuprofen ..... YES NO
   f. Codeine or other narcotics ..... YES NO
   g. Latex ..... YES NO
   h. Adhesive tape (skin reaction) ..... YES NO
   i. Other _____

MEDICAL/DENTAL HISTORY for _____

10. Have you or a family member ever had an unusual reaction from being put to sleep for surgery? ..... YES NO
11. Have you ever required unusually large amounts of local anesthetic for medical or dental treatment ..... YES NO
12. Have you ever had any operation(s) under General Anesthesia or IV Sedation? .. YES NO
    If so, please list operation with date (year) _____
    _____
13. Have you been hospitalized or had a serious illness within the past 5 years? ..... YES NO
    If so, what was the illness/injury? _____

14. Do you have any of the following diseases or problems?
    a. Fainting spells, seizures, neurological disorders ..... YES NO
    b. Rheumatic fever or rheumatic heart disease ..... YES NO
    c. Congenital heart lesions, damaged heart valves ..... YES NO
    d. Heart murmur (including Mitral Valve Prolapse) ..... YES NO
    e. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke) ..... YES NO
        1) Do you have pain in your chest upon exertion? ..... YES NO
        2) Are you ever short of breath after mild exertion? ..... YES NO
        3) Do your ankles swell? ..... YES NO
        4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ..... YES NO
        5) Do you have a cardiac pacemaker? ..... YES NO
        6) Do you have an artificial heart valve? ..... YES NO
    f. High blood pressure ..... YES NO
    Low blood pressure ..... YES NO
    g. Allergies or hay fever ..... YES NO
    h. Asthma, bronchitis or emphysema ..... YES NO
    i. Hives or skin rash ..... YES NO
    j. Diabetes ..... YES NO
    k. Hyper or hypothyroidism ..... YES NO
    l. Hepatitis, jaundice or liver disease ..... YES NO
    m. Kidney trouble ..... YES NO
    n. Arthritis, inflammatory rheumatism (painful swollen joints) ..... YES NO
    o. Artificial Joints (hip, knee, etc.), osteoporosis ..... YES NO
    p. Stomach ulcers ..... YES NO
    q. Tuberculosis ..... YES NO
    r. Do you have a persistent cough or cold? ..... YES NO

MEDICAL/DENTAL HISTORY for _____

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Prosthodontics & Cosmetic Dentistry

14. Do you have any of the following diseases or problems?
    s. Frequent diarrhea or blood in your stools? ..... YES NO
    t. Immune deficient disease ..... YES NO
    u. Venereal disease (syphilis, gonorrhea ..... YES NO
    v. Cold sores, fever blisters, herpes ..... YES NO
    w. Cancer, cyst or malignancy ..... YES NO
    x. Radiation therapy, Chemotherapy ..... YES NO
    y. Glaucoma ..... YES NO
    z. Psychiatric treatment or emotional disturbance ..... YES NO
        aa. Nervous, anxious ..... YES NO
        bb. Other_____

15. Have you ever had abnormal bleeding associated with extractions or surgery? ... YES NO
    a. Do you bleed easily? ..... YES NO
    b. Have you ever required a blood transfusion? ..... YES NO
    If so, explain the circumstances _____
16. Do you have any blood disorder such as anemia or sickle cell? ..... YES NO
17. Do you have any disease, condition or problem not listed above that you think the doctor should know about? ..... YES NO
    If so, please explain _____
18. Are you wearing contact lenses? ..... YES NO
19. Do you drink alcohol? ..... YES NO
    If so, how much and how often?_____
20. Do you smoke or use tobacco? ..... YES NO
    If so, how much and how often? _____
21. Do you use recreational / street drugs? ..... YES NO

WOMEN

22. Are you pregnant? ..... YES NO
23. Are you nursing? ..... YES NO

RESPONSIBILITY AND CONSENT FOR TREATMENT

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. The information provided on this form is accurate and truthful. Should further information be needed, you have my permission to ask the respective health care provider or agency, who will release such information to you. I will notify the doctor of change in my health or medication.

_____ _____
Signature of Patient or Guardianab Date

_____ _____
Signature of Dentist Date

MEDICAL/DENTAL HISTORY for _____

Welcome! So that we may provide you with the best possible care please complete both these medical and dental forms. All information is completely confidential.

YOUR DENTAL HEALTH

1.What is the reason for your visit today? _____

_____

2. Date of your last Dental Exam _____
   Dentist's Name _____
3. Date of your last Dental Cleaning
   Last Full Mouth X-rays _____
4. Are you in any discomfort or pain at this time ..... YES NO
5. Are you satisfied with the appearance of your teeth? ..... YES NO
6. Are you able to eat and chew foods satisfactorily? ..... YES NO
7. Do you have or have you had any of the following? Please indicate with an (x)

( ) Teeth sensitive to cold/hot/sweet	( ) Gums bleed or hurt	( )Food gets caught between teeth
( ) Loose teeth or change in bite	( ) Blisters on lips/mouth	( ) Swelling or lump in the mouth
( ) Teeth sensitive to biting/chewing	( ) Bad breath	( ) Unpleasant taste
( ) Periodontal (gum) treatment	( ) Orthodontic treatment	( ) Endodontic treatment (root canal)
( ) Oral surgery	( ) Injury to mouth/head	( ) Complications with extraction
( ) Difficulty opening jaw	( ) Clenching or grinding	( ) Clicking/popping of the jaw joint
( ) Mouth breather	( ) Bite plate/nightguard	( ) Teeth ground or bite adjusted
( ) Smoke cigarettes, pipe, cigar	( ) Use chewing tobacco	( ) Do you use mouthwash
( ) Do you brush daily	( ) Do you floss daily	( ) Fluoride supplements
( ) Use an Electric toothbrush	( ) Use a Waterpik	( ) Denture adhesive

8. Have you ever had any problems with any previous dental care? ..... YES NO
   If yes, please explain _____
9. Would you like to keep your teeth all of your life? ..... YES NO
10. Do you feel nervous about having dental treatment? ..... YES NO

If yes, what is your biggest concern? _____

11. Is there anything else about having dental treatment you would like us to know? YES NO
    If yes, please explain _____

_____

_____