

Patient Information

Name: _____
Last Name First Name

Medical Alert _____

Dental History

Major Reason for seeking dental care _____

How long has it been since you have been to dentist? _____

When were your last dental X-rays? _____ Your last cleaning date? _____

Would you like to keep your teeth all your life? Yes ___ No ___

Did you have previous consultation and/or treatment by periodontist? Yes ___ No ___ When _____ Dentist _____

Did you have previous consultation and /or orthodontic treatment? Yes ___ No ___ When _____ Dentist _____

Do you ever have any clicking, popping, or pain in jaw joint? Yes ___ No ___ When _____

Have you ever had any complication from tooth extraction or other dental procedures? _____

Have you ever had a difficult experience at a dental office that we should know about? _____

Is there anything about your smile that you would like to change? _____

Are you interested Cosmetic Consultation (Veneers, bonding, full mouth reconstruction, whitening, etc) Yes ___ No ___

Medical History

Physicians Name: _____ Tel: (____) _____ - _____

Address _____
Street City State Zip Code

Date of last medical examination _____

Have you ever had any serious illness or operation or been hospitalized within last 5 years? Yes ___ No ___

If yes explain _____

Are you currently being treated or have been treated in the last year by a physician? Yes ___ No ___

If yes explain _____

The following may require pre-medication: Heart Disease, Heart murmur, Rheumatic Fever, Artificial transplant, Artificial Joint replacement.

Do you have any of the following?	Yes	No
Heart (Surgery, Disease, Attack)		
Chest Pain		
Congenital Heart Disease		
Heart Murmur		
Abnormal Blood Pressure High ___ Low ___		
Mitral Valve prolapse		
Artificial Heart Valve		
Heart Pacemaker		
Rheumatic Fever		
Arthritis / Rheumatism		
Cortisone Medicine		
Swollen Ankle		
Stroke		
Diet (Special / Restricted)		
Artificial joint (hip, Knee, etc)		
Kidney Trouble		
Ulcers		
Diabetes		
Thyroid Problem		
Glaucoma		
Contact lenses		
Emphysema / Asthma		
Chronic Cough		
Tuberculosis		

Do you have any of the following?	Yes	No
Hay Fever		
Latex Sensitivity		
Allergies or Hives		
Sinus Trouble		
Radiation Therapy		
Chemotherapy		
Tumors		
Hepatitis A (infectious) B (Serum)		
Venereal disease		
A.I.D.S.		
H.I.V. Positive		
Cold Sores / Fever Blaster		
Blood Transfusion		
Hemophilia		
Sickle Cell Disease		
Bruise Easily		
Liver Disease		
Eye Disease		
Ear Trouble		
Yellow Jaundice		
Mental Disorders, Neurological disorder		
Epilepsy, Seizures, Fainting Spells		
Nervous / Anxious		
Psychiatric / Psychological Care		

Patient Medical History

www.greatsmilesarehere.com

Dr. Mary Zarekari

(925) 939-9177

Do you have or have you have any condition, or problem not listed? _____
Have you taken any medication or drugs during the past 2 years? _____

Are you taking?

	Yes	No
Anticoagulant		
Steroid		
Aspirin		
Insulin or oral Medication for diabetes		
Oral Contraceptive or birth Control pi		
Weight loss (diet pills)		
High Blood Pressure Medication		

	Yes	No
Antihistamines		
Fen-Phen (Fenfluramine-Phentermine)		
Pondimin (Fenfluramine)		
Redux (Dexfenfluramine)		
Nitroglycerine		
Hormonal therapy		

Others: (if so what condition): _____

Are you sensitive or allergic or have reacted adversely to any medications:

	Yes	No
Dental Anesthetic		
Metals (copper, nickel, etc)		
Barbiturates, Sedative		
Aspirin		

	Yes	No
Sulfa drugs		
Penicillin or other antibiotics		
Codeine, Demerol, or narcotics		

Do you use tobaccos regularly? Yes ___ No ___ How Much _____

Others: (if so what condition): _____

Have you had a reaction to dental anesthesia / injection or gas? Yes ___ No ___

Remarks about your health we should know: _____

Woman

Are you pregnant: Yes ___ No ___ Delivery Date? _____
Nursing Yes ___ No ___ Taking Birth Control Pills Yes ___ No ___

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. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of change in my health or medication.

Print Name

Signature of Patient

Date

(Parent or guardian if minor)

X

X

X

History Review

Witness

Signature

Date