Updated Medical History for Existing Patients

CONFIDENTIAL

Name: _____ Date of Birth: _____

		No	Yes	
A	Are you presently under the care of your physician?	☐	☐	_____
B	Are you presently under the care of a medical specialist?	☐	☐	_____
C	Are you taking any medication?	☐	☐	_____
D	Are you allergic to any medication?	☐	☐	_____
E	Any adverse reaction to ASA? Codeine? Penicillin? Sulfa?	☐	☐	_____
F	Do you have any other allergies, hay fever or asthma?	☐	☐	_____
G	Do you bruise easily or have prolonged bleeding?	☐	☐	_____
H	Do your ankles or feet swell?	☐	☐	_____
I	Do you experience shortness of breath or chest pain?	☐	☐	_____
J	Do you have spells of dizziness or fainting?	☐	☐	_____
K	Have you ever had an injury to your face, head, or jaw?	☐	☐	_____
L	Have you ever had major surgery?	☐	☐	_____
M	Do you smoke?	☐	☐	How many per day? _____
N	Are you pregnant?	☐	☐	Due date: _____

Have you ever been treated for:

	No	Yes			No	Yes	
1	☐	☐	RHEUMATIC FEVER	13	☐	☐	CANCER
2	☐	☐	LUNG DISEASE	14	☐	☐	JOINT REPLACEMENT
3	☐	☐	HEART MURMUR (M.V.P)	15	☐	☐	JAUNDICE
4	☐	☐	HEART DISEASE	16	☐	☐	SCARLET FEVER
5	☐	☐	TUBERCULOSIS	27	☐	☐	DIABETES
6	☐	☐	GALL BLADDER DISEASE	18	☐	☐	PACEMAKER
7	☐	☐	HEART ATTACK	19	☐	☐	EPILEPSY
8	☐	☐	STROKE	20	☐	☐	HIGH BLOOD PRESSURE
9	☐	☐	LIVER OR KIDNEY DISEASE	21	☐	☐	DIPHTHERIA
10	☐	☐	ARTHRITIS	22	☐	☐	ANEMIA
11	☐	☐	GLAUCOMA	23	☐	☐	ULCERS/STOMACH PROBLEMS
12	☐	☐	SINUS PROBLEMS				

P Have you been tested for: ☐ HEPATITIS ☐ H.I.V (AIDS)

Are there any medical concerns we should be aware of?

_____

The above information is complete to the best of my knowledge, and I have not omitted any pertinent information

_____ _____ _____

SIGNATURE DATE H. Klaiman, DDS

NOTES: _____

_____

_____

_____

Name: _____ Referred by: _____

Address: _____

City: _____ P.C. _____

Telephone: Home: _____

Work: _____

Other: _____

Email: _____

Person responsible for account

Address: _____

City: _____ P.C. _____

Telephone: Home: _____

Work: _____

Physician's Name

Name: _____

Telephone: _____

Address: _____

City: _____ P.C. _____

PRIMARY

Policy Holder _____

Date of Birth _____

Employer _____

Benefit Carrier _____

Policy # _____

Certificate # _____

signature _____

SECONDARY

Policy Holder _____

Date of Birth _____

Employer _____

Benefit Carrier _____

Policy # _____

Certificate # _____

signature _____

DENTAL HISTORY

In your own words, please tell us what brought you to our office today:

_____

_____

Have you been referred to another dental specialist? ☐ Yes ☐ No

If so, what treatment was completed? _____

Have you ever suffered an injury to your head or jaw? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No When?_____ Why?_____

Do you notice yourself clenching or grinding your teeth? ☐ Yes ☐ No

Does your jaw crack or pop when you open and close your mouth?

Do your gums ever feel tender or bleed? ☐ Yes ☐ No

Have you had local anaesthetic at the dentist? ☐ Yes ☐ No Any adverse reactions? _____

How frequently do you see your dentist? _____

What do you do at home to care for your teeth? _____

Is there anything else that concerns you about your teeth or your mouth?_____