Dental and Medical History Form

Svetlana Smirnova DDS. PA

NAME:____ **DOB:** ____________________

1) THE MAIN REASON FOR MY DENTAL APPOINTMENT IS: ____

____

____

2) ARE YOU IN DENTAL PAIN? ☐ YES ☐ NO

IF YES, ON THE PAIN SCHEDULE TO THE RIGHT PLEASE CIRCLE HOW MUCH PAIN YOU ARE IN:

WHERE IS THE PAIN?

☐ UPPER RIGHT ☐ UPPER FRONT ☐ UPPER LEFT
☐ LOWER RIGHT ☐ LOWER FRONT ☐ LOWER LEFT

DESCRIBE THE PAIN: ☐ THROBBING, ☐ SHARP, ☐ CONSISTENT, ☐ INTERMITTENT, ☐ DULL

PAIN RATING SCALE

No Pain	Lite Pain	Hurts	More Pain	A lot of Pain	Worse Pain

3) DATE OF LAST DENTAL EXAMINATION (MM/YY) __________________

4) HOW SATISFIED HAVE YOU BEEN WITH YOUR PREVIOUS DENTAL CARE? 1 2 3 4 5

NOT SATISFIED ... VERY SATISFIED

5) DO YOU FEAR RECEIVING DENTAL CARE? ☐ YES ☐ NO ☐ UNSURE

THE FOLLOWING INFORMATION IS ESSENTIAL FOR THE SAFE AND EFFECTIVE DIAGNOSIS AND TREATMENT OF EACH PATIENT.
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

		YES	NO
6)	CONGENITAL HEART DISEASE/HEART MURMUR/RHEUMATIC FEVER		
7)	HEART ATTACK		
8)	IRREGULAR HEART BEAT		
9)	ANGINA/CHEST PAIN		
10)	HEART SURGERY		
11)	ARTIFICIAL HEART VALVE		
12)	HEART PACE MAKER		
13)	HIGH BLOOD PRESSURE		
14)	LOW BLOOD PRESSURE		
15)	STROKE/PARALYSIS		
RESPIRATORY			
16)	ASTHMA		
17)	BREATHING PROBLEM (SLEEP APNEA EMPHYSEMA,SHORTNESS OF BREATH, OXYGEN DEPENDENT,COUGH)		
18)	TUBERCULOSIS		
GASTRO-INTESTINAL			
19)	KIDNEY DISEASE		
20)	LIVER DISEASE/YELLOW JAUNDICE		
21)	STOMACH/INTESTINAL DISEASE/ ULCERS REFLUX		

NEUROLOGY		
22) CONVULSIONS/SEIZURES/EPILEPSY		
23) NUMBNESS OR TINGLING/BACKPAIN		
24) PSYCHIATRIC TREATMENT		
25) FAINTING/DIZZINESS		
ENDOCRINE		
26) DIABETES TYPE 1 TYPE 2		
27) STEROID TREATMENT (CORTISONE)		
28) THYROID PROBLEM		
HEMATOLOGY		
29) BLEEDING/BRUISING EASILY/ BLOOD DISORDER		
30) IMMUNE SYSTEM (LUPUS, IMMUNODEFICIENCY, SJOGRENS)		
INFECTIOUS DISEASE		
31) HIV/AIDS		
32) HERPES		
33) HEPATITIS A, B or C		
MUSCULOSKELETAL		
34) RHEUMATISM/ARTHRITIS/PAIN IN JOINTS		
35) ARTIFICIAL JOINT		
36) OSTEOPOROSIS/BISPHOSPHONATE THERAPY		
GENERAL		
37) CURRENT CANCER		
38) PAST CANCER		
39) RADIATION THERAPY		
40) CHEMOTHERAPY		
41) RECENT WEIGHT GAIN/LOSS		
42) FEN-PHEN USE		
43) DRUG/ALCOHOL TREATMENT		
44) HIVES/RASH		
45) DIFFICULTY HEARING		
46) EYE PROBLEMS (DRY EYES/GLAUCOMA)		
47) WOMEN ONLY:		
ARE YOU OR COULD YOU BE PREGNANT?		

48) DO YOU HAVE ANY OTHER MEDICAL CONDITIONS NOT LISTED? ______________________

49) HAVE YOU EXPERIENCED AN UNUSUAL OR ALLERGIC REACTION TO ANY OF THE FOLLOWING?

☐ LOCAL ANESTHETIC ☐ CODEINE ☐ ASPIRIN
☐ PENICILLIN ☐ NARCOTICS ☐ METALS
☐ SULFA DRUGS ☐ LATEX RUBBER ☐ OTHERS ______________________

50) HAVE YOU BEEN HOSPITALIZED IN THE PAST YEAR? ☐YES ☐NO

IF YES, WHAT/WERE YOU TREATED FOR? ______________________

51) PLEASE LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING OVER THE COUNTER, SUPPLEMENTS, OR HERBALS):

NAME	DOSAGE	ROUTE OF INTAKE	MEDICAL CONDITION

52) TOBACCO USE

CIGARETTES

☐ QUIT: DATE ______________

☐ NEVER

☐ CURRENT SMOKER: PACKS/DAY_______# OF YRS ________

OTHER TOBACCO: ☐ PIPE ☐ CIGAR ☐ SNUFF ☐ CHEW ☐ BETEL QUID

ARE YOU INTERESTED IN QUITTING ? YES NO

53) ALCOHOL USE

DO YOU DRINK ALCOHOL? YES NO # DRINKS/WEEK______

53) DO YOU HAVE ACCESS TO MEDICAL CARE?

NAME OF FACILITY:____

DOCTORS NAME: ______________________________ PHONE:______________________________

I CERTIFY THAT ALL THE INFORMATION I HAVE PROVIDED IS TRUE TO MY KNOWLEDGE.

DATE SIGNATURE

(Electronic signature aquired upon review with the provider)