**MEDICAL INFORMATION**

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle and explain if necessary.

1. **PHYSICIAN NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PHONE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Has there been any change in your health within the past year? ……………………………………..Yes / No

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Your last physician examination was on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Are you now under the care of a physician? …………………………………………………………….Yes / No

 If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Have you ever had any serious illness or operation? .………………………………………………….Yes / No

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Have you been hospitalized within the last five years? …………………………………………………Yes / No

 If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Are you allergic or have you reacted adversely to any of the following medications? .....................Yes / No

 Asprin Nitrous Oxide Valium Local Anaesthetic

 Darvon Erythromycin Scopolamine (Novocain or Xylocaine)

 Codeine Tetracycline Penicillin Sleeping Pills

 Demerol Percodan Other Antibiotics (Nembutal/Seconal)

8. Are you aware of being allergic to any other medications or substance? ……………………………Yes / No

If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Circle any other of the following which you have had or have at present:

 Heart Failure Emphysema A.I.D.S.

 Heart Disease or Attack Cough Hepatitis A (infectious)

 Angina Pectoris Tuberculosis (TB) Hepatitis B (serum)

 High Blood Pressure Asthma Hepatitis C

 Heart Murmur Hay Fever Liver Disease

 Rheumatic Fever Sinus Trouble Yellow Jaundice

 Congenital Heart Lesions Allergies or Hives Blood Transfusion

 Scarlet Fever Diabetes Drug Addiction

 Artificial Heart Valve Thyroid Disease Hemophillia

 Heart Pacemaker X-ray or Cobalt Treatment Venereal Disease

(Syphillis, Gonorrhea)

 Heart Surgery Chemotherapy (Cancer, Leukemia) Cold Sores

 Artificial Joints (Hip, Knee) Arthritis Fever Blisters

 Anemia Rheumatism Epilepsy or Seizures

 Stroke Cortisone Medicine Fainting or Dizzy Spells

 Kidney Trouble Glaucoma Nervousness

 Ulcers Pain in Jaw Joints Psychiatric Treatment

 Cosmetic Surgery Cancer Sickle Cell Disease

 Bruise Easily

10. Have you ever had abnormal bleeding associated with previous extraction, surgery or trauma? .Yes / No

11. Are you taking any drugs or medications? ……………………………………………………………Yes / No If yes, what are the name(s). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Are you taking **Biphosphonates**? ………………………………………………………………………Yes / No

12. Female patients : Are you pregnant? Yes / No If yes, which trimester?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Do you have any disease, condition or problem not listed above that you think Dr Sretavan should know

Yes / No If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DENTAL HISTORY**

1. Date of last dental visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What dental condition concerns you now?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are you having pain or discomfort at this time?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you feel very nervous about having dental treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Have you ever had a bad experience in the dental office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Have you had regular dental care (annually) in the past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Do you have any oral habits such as clenching, grinding your teeth, or nail biting?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Do you hear “popping” or clicking sounds from your “jaw joints”?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Are you aware of any swelling or lump in your mouth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Do you use a toothbrush?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

About how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had tooth brushing instructions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you use dental floss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

About how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had instruction in using dental floss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you satisfied with the function and appearance of your teeth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever had or do you now have any of the following?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bridges Extractions Gum surgery

Partial dentures Loose teeth Surgery in your mouth

Full dentures Orthodontic treatment Sensitive teeth (Hot / Cold)

Root canal fillings Swelling in your mouth or jaws Bleeding gums

Lost fillings Injuries to your face or jaw Oral implants

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have provided the above information to the best of my knowledge, and I agree to notify Dr. Michael Sretavan’s dental office if there are any changes to my medical conditions.

**Patient or Parent Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_