Medical-Dental History

Patient's Name_____ DOB_____

All questions must be answered to properly evaluate your current health status. It may be necessary for the dentist to contact your physician. Included on this form is Permission to Release Information. Please fill this form out honestly and to the best of your ability.

ALL INFORMATION YOU SUPPLY ON THIS FORM AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR WRITTEN PERMISSION.

Name, address and phone number of your **Primary Care Physician (your doctor):**
_____

Last visit to your physician _____Purpose of visit _____

Do you suffer from a disability? ___ Please describe_____

Have you ever, or do you now take illegal drugs_____ Please describe_____
***There are drugs and medications used in routine dental care that are incompatible with several illegal drugs that the combination can be dangerous to your health and may be fatal.*

Please list any medications including over the counter medications that you are taking:
_____
_____

***There are many drug and medication incompatibilities, some of which my result in dangerous health problems. Information about your current use of medications is essential.*

Are you allergic to any medications? ___ Please describe_____

Have you ever taken Phen-Phen /Redux? ____ When_____ How long? _____

For Females:	Yes	No	Due date:
Are you pregnant or think you are pregnant?	___	___	_____
Are you nursing?	___	___	
Are you currently taking an oral contraceptive?	___	___	

***There are many drugs and medications used in routine dental care that decrease the effectiveness of oral contraceptives.*

Do you have AIDS, or are you HIV positive? __ If yes please describe and provide current status
_____

Have you ever had, or do you now have hepatitis? __ Describe _____

Please mark **None_** *at the end if you haven't been treated for:*
Rheumatic fever __Rheumatic heart disease __ Heart murmur __or congenital heart disease__ **None__**

_____

Heart attack__ Angina __ Heart surgery __ Pacemaker __ Irregular heart beats__ **None__**
_____

Stomach disease __Intestinal disease _ Abnormal blood pressure __ Excessive bleeding __ Anemia __ **None** __
_____

Breathing problems __Asthma __ Tuberculosis __ Hay Fever __ **None__** _____

Cancer__ Radiation __ Chemotherapy __ **None __** _____

Diabetes __ Kidney problems __ Renal dialysis __ **None__** _____

Stroke __ Fainting __ Seizures __ Epilepsy/Convulsions __ **None__** _____

Tumors ___ Growths __ **None__** _____

Arthritis __ Rheumatism __ Joint Replacement __ **None__** _____

Have you ever had a major operation? _____

Have you ever had serious injury to your head or neck? _____

Do you smoke? ____ Pleas describe type and quantity _____

Are there any other problems about your health of which you are aware _____

Dental History:

Date of your last dental visit _____ Reason for this visit _____

Do you have your dental X-Rays with you? _____

During previous visits have you experienced the following?

Fainting? _____

Any allergic reactions? _____

Abnormal bleeding? _____

Complications during or after treatment? _____

Do your gums bleed when brushing or eating? _____

Does food catch between your teeth? _____

Do you grind your teeth or clench your jaw? _____

Have your teeth shifted? _____

Are your teeth sensitive? _____

Have you ever had sore jaw muscles? _____

A CHANGE IN YOU HEALTH STATUS SHOULD BE REPORTED TO US AT THE EARLIEST POSSIBLE TIME

Permission to Release Health Information

I grant permission for Dr. Goldberg to discuss information about my dental treatment with third party payors/and or health care practitioners.

_____ _____

Signature of patient/guardian Date

_____

Signature of doctor