Murad Gharibian, D.D.S. Inc.
DG Dental

Patient's Name_____ Physician Name & No._____

PATIENT MEDICAL HISTORY

		YES	NO
1.	Are you under medical treatment now?	☐	☐
2.	Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3.	Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____ _____	☐	☐
4.	Do you use tobacco?	☐	☐
5.	Do you use alcohol, cocaine or other drugs?	☐	☐
6.	Are you wearing contact lenses?	☐	☐

7. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (eg. Novocaine)	☐	☐	Barbiturates			
☐	☐	Penicillin or other Antibiotics	☐	☐	Sedatives			
☐	☐	Sulfa drugs	☐	☐	Iodine			
☐	☐	Aspirin	☐	☐	Other _____			

		YES	NO
8.	**WOMEN ONLY:**		
a)	Are you pregnant or think you may be Pregnant?	☐	☐
b)	Are you nursing?	☐	☐
c)	Are you on any kind of birth control? _____ _____	☐	☐

9. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies
☐	☐	Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble
☐	☐	Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles/Ulcers			_____

PATIENT DENTAL HISTORY

		YES	NO
1.	Do your gums bleed while brushing or flossing?	☐	☐
2.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3.	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4.	Do you feel pain to any of your teeth?	☐	☐
5.	Do you have any sores or lumps in or near your mouth?	☐	☐
6.	Have you had any head, neck or jaw injuries?	☐	☐
7.	Have you ever experienced any of the following problems in your jaw?	☐	☐
	a) Clicking?	☐	☐
	b) Pain (joint, ear, side of face)?	☐	☐
	c) Difficulty in opening or closing?	☐	☐
	d) Difficulty in chewing?	☐	☐

		YES	NO
8.	Do you have frequent headaches?	☐	☐
9.	Do you clench or grind your teeth?	☐	☐
10.	Do you bite your lips or cheeks frequently?	☐	☐
11.	Have you ever had any difficult extractions in the past?	☐	☐
12.	Have you had any orthodontic work?	☐	☐
13.	Have you ever had prolonged bleeding following extractions?	☐	☐
14.	Have you ever had instructions on the correct method of brushing your teeth?	☐	☐
15.	Have you ever had instructions on the care of your gums?	☐	☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE **X**_____ **DATE** _____

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