AA

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Medical & Dental History

Your health affects your dental care. This information is confidential and helps Dr. Asgharzadeh treat you safely. Please answer every question.

Patient name

Date of birth (MM/DD/YYYY)

General health

Are you currently under a physician's care? Yes No For what?

Have you been hospitalized or had surgery in the past five years? Yes No Details

Has a physician advised you to take antibiotics before dental treatment? Yes No

Have you ever taken bisphosphonates or similar bone medications (e.g. Fosamax, Boniva, Prolia)? Yes No

Please check any condition you have now or have had in the past:

- ☐ Allergies / hay fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial joint replacement
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Bleeding or clotting disorder
- ☐ Blood thinner use
- ☐ Cancer / chemotherapy
- ☐ Radiation to head or neck
- ☐ Diabetes
- ☐ Epilepsy / seizures
- ☐ Fainting or dizziness
- ☐ Acid reflux (GERD)
- ☐ Glaucoma
- ☐ Heart attack or heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease / COPD
- ☐ Osteoporosis
- ☐ Pacemaker or defibrillator
- ☐ Rheumatic fever
- ☐ Sleep apnea / snoring
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Anxiety or depression
- ☐ Tobacco or vaping
- ☐ Alcohol use (daily)
- ☐ Other (list below)

Other conditions or details

Medications

List all prescription and over-the-counter medications, vitamins and supplements you take (name and dose)

Allergies

- ☐ No known allergies
- ☐ Penicillin or other antibiotics
- ☐ Codeine or other opioids
- ☐ Local anesthetics
- ☐ Latex
- ☐ Aspirin or ibuprofen (NSAIDs)
- ☐ Metals (e.g. nickel)
- ☐ Iodine
- ☐ Other (list below)

Allergy details and reactions

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Medical & Dental History

continued

For women

Are you pregnant or could you be pregnant? ○ Yes ○ No Weeks _____

Are you nursing? ○ Yes ○ No

Are you taking oral contraceptives or hormone therapy? ○ Yes ○ No

Dental history

Main reason for today's visit

Date of last dental visit | Date of last dental X-rays | Previous dentist

Have you had any of the following?

- ☐ Orthodontics (braces / aligners)
- ☐ Gum (periodontal) treatment
- ☐ Root canal
- ☐ Tooth extraction
- ☐ Dental implant
- ☐ Crowns or bridges
- ☐ Dentures or partials
- ☐ Night guard
- ☐ Problems with dental anesthesia

Do you have any of these concerns now?

- ☐ Bleeding gums
- ☐ Sensitivity to hot or cold
- ☐ Tooth pain
- ☐ Clenching or grinding
- ☐ Jaw pain or clicking (TMJ)
- ☐ Bad breath
- ☐ Dry mouth
- ☐ Loose teeth
- ☐ Food catching between teeth
- ☐ Chipped or broken teeth
- ☐ Unhappy with color or appearance
- ☐ Interested in whitening

Anything else you'd like Dr. Asgharzadeh to know about your teeth or your goals?

Your comfort

How do you feel about dental visits?

○ Relaxed ○ A little nervous ○ Moderately nervous ○ Very anxious

What helps you feel more comfortable? (e.g. breaks, explanations before each step, music)

Signature

To the best of my knowledge, the information above is complete and correct. I will tell the office about any changes in my health or medications.

Patient (or parent/guardian) signature (type your name, or sign on paper) | Date (MM/DD/YYYY)