

Irwin C. Mishoulam, D.D.S.
 Patient Medical and Dental History

Name _____

Medical History

Physician _____	Office Phone # _____	Date of last exam _____		
	Yes No		Yes No	
1. Are you under medical treatment now?	___	___	10. Are you allergic to or have you had any reactions to the following?	
2. Have you ever been hospitalized for any Operation or serious illness within the last 5 years? If yes, please explain:	___	___	Local Anesthetics (Novocain)	___
	___	___	Penicillin or any antibiotic	___
3. Are you taking any medications including non prescription medication? Please list:	___	___	Sulfa drugs	___
_____	___	___	Barbiturates	___
4. Have you ever taken Phen-Fen/Redux?	___	___	Sedatives	___
5. Do you use tobacco?	___	___	Iodine	___
6. Do you use controlled substances?	___	___	Aspirin	___
7. Are you wearing contact lenses?	___	___	Metals (nickel, mercury)	___
8. Are you pregnant or think you might be?	___	___	Other: _____	___
9. Please check all that apply:	___	___	11. Are you taking oral contraceptives?	___
	Yes	No	12. Are you nursing?	___
Aids/HIV infection	___	___	13. Do you take an aspirin daily?	___
Allergies/Hay Fever	___	___		Yes
Anemia	___	___	No	Yes
Angina/Chest Pain	___	___	Implant	___
Arthritis	___	___	Joint Replacement	___
Asthma	___	___	Kidney Disease	___
Cancer	___	___	Leukemia	___
Cardiac Pacemaker	___	___	Liver Disease	___
Diabetes	___	___	Low Blood Pressure	___
Recent Weight Loss	___	___	Mitral Valve Prolapse	___
STD	___	___	Osteoporosis	___
Thyroid Problems	___	___	Radiation Therapy	___
			Rheumatic Fever	___
			Swollen Ankles	___
			Other _____	___

Dental History

Previous Dentist _____	Phone # _____	Last Cleaning/Exam _____
	Yes No	Yes No
1. Do your gums bleed while brushing/ flossing?	___	___
2. Are your teeth sensitive to hot or cold?	___	___
3. Are your teeth sensitive to sweet or sour?	___	___
4. Do you feel pain in any of your teeth?	___	___
5. Do you have any sores/lumps in mouth?	___	___
6. Have you had head, neck or jaw injuries?	___	___
7. Have you experienced the following problems in your jaw?		
Clicking	___	___
Pain (joint, ear, side of face)	___	___
Difficulty opening/closing your mouth	___	___
Difficulty in chewing	___	___
8. Do you have frequent headaches?	___	___
9. Do you clench or grind your teeth?	___	___
10. Do you bite your lips or cheeks?	___	___
11. Have you had a difficult extraction?	___	___
12. Have you had prolonged bleeding after an extraction?	___	___
13. Have you had orthodontics?	___	___
14. Do you wear dentures or partials? If yes, date of placement _____	___	___
15. Have you received oral hygiene instructions on gum/teeth care?	___	___
16. Do you like your smile?	___	___
17. Have you ever had a negative experience at a dentist? If yes, please describe:		

Authorization and Release

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors/health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. **I agree to be responsible for payment of all services rendered on my behalf or my dependents.**

Your Signature X _____ Date _____