Sergio Moncada DDS INCORPORATED

PATIENT NAME _____ BIRTHDATE _____

PATIENT MEDICAL AND DENTAL HISTORY

Please answer all questions and check appropriate Yes or No boxes.

	Yes	No
Have you ever been hospitalized for any surgical intervention or serious illness?	□	□
If yes, Reason: _____		
Are you under any medical treatment?	□	□
If yes, Reason: _____		
PHYSICIAN'S NAME AND PHONE NUMBER _____		
Are you taking any prescription or over the counter medications?	□	□
Do you require antibiotics before dental treatment?	□	□
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing **bisphOsphonAtes ?**	□	□
Have you ever taken any of the **Fen-Phen** group of drugs?	□	□
Are you using or have you ever used any recreational drugs (marijuana, cocaine, etc.)	□	□
Women: Are you pregnant or think you may be pregnant?	□	□
Are you taking birth control pills?	□	□

	Yes	No
Have you ever had trouble with a previous dental treatment? (passed out, dizzy, other)	□	□
Have you ever had any prolonged bleeding after dental extraction?	□	□
Have you ever had Periodontal (Gum) Treatment?	□	□
Do your gums bleed while brushing or flossing?	□	□
Do you clench or grind your teeth? (awake or asleep)	□	□

Reason for today's visit: _____

When was your last visit to the dentist? Date: _____

When was the last time you had X-Rays taken? Date: _____

Please mark if you ever had:

□ Burning tongue/lips. □ Swelling/lumps in mouth or neck.

□ Blisters/sores on lip or mouth.

Please mark if your **teeth** are sensitive to:

□ Cold □ Hot □ Sweet □ Pressure □ While Chewing

Please mark if you feel in your **jaw** any:

□ Discomfort □ Clicking □ Popping □ Pain

□ Difficulty chewing □ Difficulty opening or closing jaw

Are you allergic or had an allergic reaction to any of the following:

Please check appropriate Yes or No boxes

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Penicillins	□	□	Latex	□	□	Sedatives	□	□	Codeine	□	□	Jewelry/Metals	□	□
Anesthetic	□	□	Acrylic	□	□	Aspirin	□	□	Iodine	□	□	Other Allergies?	□	□

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

Please check appropriate Yes or No boxes

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV *	□	□	Congenital Heart Lesions	□	□	Hemophilia *	□	□	Psychological Care	□	□
Anemia	□	□	Diabetes	□	□	Hepatitis A B C (circle)	□	□	Radiation Therapy *	□	□
Arthritis/Rheumatism	□	□	Difficulty Breathing	□	□	High Blood Pressure	□	□	Rheumatic Fever	□	□
Artificial Heart Valve *	□	□	Emphysema	□	□	Low Blood Pressure	□	□	Stomach Problems	□	□
Artificial Bone or Joints *	□	□	Epilepsy or Seizures	□	□	Cholesterol	□	□	Stroke	□	□
Asthma	□	□	Glaucoma	□	□	Kidney Trouble	□	□	Swollen Feet or Ankles	□	□
Blood Disease	□	□	Heart Problems *	□	□	Liver Disease	□	□	Thyroid Problems	□	□
Blood Transfusion	□	□	Heart Murmur	□	□	Nervousness or Anxiety	□	□	Tuberculosis (TB) *	□	□
Cancer/Chemotherapy *	□	□	Heart Pacemaker *	□	□	Neurological Disorders	□	□	Venereal Disease/STD *	□	□
Circulatory problems	□	□				Psychiatric Care	□	□			

Have you ever had any serious illness not listed above? □ YES □ NO

List them: _____

I have reviewed this medical / dental history information and had the opportunity to ask any questions:

Name of patient, parent or guardian	Signature	Date	Doctor
_____	_____	_____	_____

LIST MEDICATIONS YOU CURRENTLY TAKE

Medication:	Dosage:
_____	_____
_____	_____