Full Legal Name: ____________________ **Date of Birth** ____________

Primary Care Physician ____________________ **Specialist(s)** ____________

Last Dental Visit ____________________ **Date of Last X-rays?** ____________

Name/Address of Previous Dentist ____________________

DENTAL HISTORY

PLEASE Mark Y (yes) or N (no) for each item

Are you having discomfort today	Y N	Loose/Broken Teeth	Y N	Sores or growth in mouth	Y N
Bleeding/Swollen Gums	Y N	Sensitivity to HOT	Y N	Biting Pain /Pressure	Y N
Bad Breath	Y N	Sensitivity to COLD	Y N	Broken Fillings	Y N
Grinding or Clenching Teeth	Y N	Sensitivity to SWEETS	Y N	Clicking/Popping Jaw	Y N

How often do you brush? ____________________ Floss? ____________________

How do you feel about your smile or the appearance of your teeth? ____________________

Have you ever had an adverse reaction related to dental treatment? ____________________

Have you ever used whitening products or 'bleached' your teeth? ____________________

Dental concerns or questions? ____________________

MEDICAL HISTORY

PLEASE Mark Y (yes) or N (no) for each item

Pregnant Now	Y N	Asthma	Y N	Unexplained Fever	Y N	Legally Deaf	Y N	Esophageal Problems Reflux/GERD	Y N
Nursing Now	Y N	Emphysema	Y N	Fainting/Dizziness	Y N	Legally Blind	Y N	Gastrointestinal Problems Ulcers/IBS	Y N
Low Blood Pressure	Y N	Tuberculosis	Y N	Epilepsy/Seizures	Y N	Glaucoma	Y N	DVT Deep Vein Thrombosis	Y N
High Blood Pressure	Y N	Stroke	Y N	Thyroid Disease	Y N	Headaches	Y N	Sores/Wounds That Do Not Heal	Y N
Heart Surgery	Y N	Cancer	Y N	Kidney Disease	Y N	Arthritis	Y N	Diabetes	Y N
Artificial Heart Valve	Y N	Radiation	Y N	Liver Disease	Y N	Artificial Joints	Y N	Family History of Diabetes	Y N
Pacemaker	Y N	Chemotherapy	Y N	Hemophilia	Y N	Facial Pain	Y N	Anxiety/Depression	Y N
Do You Snore at Night	Y N	Cigar/ Pipe Use	Y N	Bleeding Problems	Y N	Sinus Trouble	Y N	Nervousness	Y N
Daytime Tiredness	Y N	Cigarette Use	Y N	Anemia	Y N	Hepatitis	Y N	Latex Allergy	Y N
Wake Up Gasping For Air	Y N	Smokeless Tobacco	Y N	Sickle Cell Anemia	Y N	Herpes	Y N	Food Allergies	Y N
Diagnosed Sleep Apnea	Y N	Drug/Alcohol Use	Y N	Hiatal Hernia	Y N	HIV Positive	Y N	Allergies to Metals	Y N
Dry Mouth	Y N	Anorexia/Bulimia	Y N	Surgical Implant	Y N	AIDS	Y N	Ever had an Anaphylactic Reaction	Y N

*****PLEASE ANSWER EACH QUESTION. MARK "N/A" IF THE QUESTION DOES NOT APPLY*****

Do any of these conditions require pre-medication (prophylactic antibiotic)? ____________________

Other illness or needs ____________________

Known allergies to medication(s): ____________________

Current medication(s): ____________________

Medicines prescribed for you, but you are NOT taking: ____________________

Herbs and/or Over The Counter Medications you are taking ____________________

(PLEASE USE REVERSE SIDE IF NEEDED)

Any hospitalizations within the past 2 years? If so, for what ____________________

Would you like to discuss anything privately with the Doctor? YES NO

I hereby attest the above information is accurate. I also give permission to the doctor and staff of this office to contact my medical doctor(s) and other health professionals for the protection of my health. This may include sending a copy of this form and/or my x-rays.

____________________ ____________ ____________________ ____________

Patient Signature Date Reviewed By Date

Frederick R. Levine, D.D.S.

2142 Rosa Road ~ Schenectady, NY 12309 ~ (518) 370-0223

www.FredLevineDDS.com