

Full Legal Name: _____ **Date of Birth** _____

Primary Care Physician _____ Specialist(s) _____

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? _____

Last Dental Visit _____ Date of last x-rays _____

Name/Address Previous Dentist _____

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 | Rheumatic Fever | Y N | Legally Deaf | Y N | Hiatal Hernia | Y N |
| Nursing Now | Y N | Emphysema | Y N | Rheumatism | Y N | Legally Blind | Y N | Jaw Pain | Y N |
| Low Blood Pressure | Y N | Tuberculosis | Y N | Fainting/Dizziness | Y N | Glaucoma | Y N | Allergies to Metals | Y N |
| High Blood Pressure | Y N | Persistent Cough | Y N | Epilepsy/Seizures | Y N | Anxiety/Depression | Y N | Sinus Trouble | Y N |
| Heart Surgery | Y N | Diabetes | Y N | Thyroid Disease | Y N | Nervousness | Y N | Nasal Allergies | Y N |
| Artificial Heart Valve | Y N | Fam Hist Diabetes | Y N | Kidney Disease | Y N | Headaches | Y N | Food Allergies | Y N |
| Pacemaker | Y N | Cancer | Y N | Liver Disease | Y N | Arthritis | Y N | Tonsillitis | Y N |
| Mitral Valve Prolapse | Y N | Radiation | Y N | Anemia | Y N | Artificial Joints | Y N | AIDS | Y N |
| Surgical Implant | Y N | Chemotherapy | Y N | Sickle Cell Anemia | Y N | Back Problems | Y N | HIV Positive | Y N |
| Swelling Hands/Feet | Y N | Hepatitis | Y N | Hemophilia | Y N | DVT | Y N | Latex Allergy | Y N |
| Circulatory Issues | Y N | Stroke | Y N | Scarlet Fever | Y N | Drug Use /Addiction | Y N | Anaphylaxis | Y N |
| Shortness of Breath | Y N | Shingles | Y N | Ulcers/Colitis | Y N | Herpes | Y N | Other | 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 _____

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 (Parent/Guardian)

Date

Reviewed By

Date

Frederick R. Levine, D.D.S.

2142 Rosa Road ~ Schenectady, NY 12309 ~ (518) 370-0223 ~ www.fredlevinedds.com