DILBER S. SRAON, DDS, INC.
& ASSOCIATES
Cosmetic & General Dentistry

## DENTAL HISTORY

Date of Last Dental Treatment: _____ Date of Last Dental X-Rays: _____

Last Dental Office: _____ Phone: _____

Have you ever had any unfavorable reaction from a local anesthetic? ☐ Yes ☐ No If Yes, Please Explain: _____

Have you ever had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No If Yes, Please Explain: _____

## MEDICAL HISTORY

Your answers are for our records only and will be considered confidential. Sex: _____ Height: _____ Weight: _____

In the following questions check yes or no, whichever applies:

1. ☐ Yes ☐ No Are you in good health?
2. ☐ Yes ☐ No Has there been any change in your general health within the past year? Date of last physical exam _____
3. ☐ Yes ☐ No Are you now, or have you been, under the care of a physician during the past two years?
   If so, what is the condition being treated? _____
4. ☐ Yes ☐ No Have you ever been hospitalized or had a serious illness? If so, what was the problem?
   _____

**Do you have or have you had any of the following diseases or conditions?**

### CARDIOVASCULAR

☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Congenital Heart Defect
Type:_____ Surgery Date:_____
☐ Yes ☐ No Angina Pectoris
Frequency:_____
☐ Yes ☐ No Myocardial Infarction (Heart Attack)
Date:_____
☐ Yes ☐ No Arrhythmias (Irregular Heart Beat)
Type:_____
☐ Yes ☐ No Cardiac Murmur
Cause:_____
☐ Yes ☐ No Congestive Heart Failure
Date:_____
☐ Yes ☐ No Heart Surgery
Type:_____ Surgery Date:_____
☐ Yes ☐ No Pacemaker Implanted
Type:_____ Date:_____
☐ Yes ☐ No Hypertension (High Blood Pressure)
BP: _____/_____
☐ Yes ☐ No Hypotension (Low Blood Pressure)
BP: _____/_____
☐ Yes ☐ No Stroke (CVA)
Date:_____
☐ Yes ☐ No Other
Explain:_____

### RESPIRATORY DISEASE

☐ Yes ☐ No Asthma
Severity:_____
☐ Yes ☐ No Emphysema
Severity:_____
☐ Yes ☐ No Hay Fever or Sinusitis
☐ Yes ☐ No Bronchitis
Severity:_____
☐ Yes ☐ No Other
Explain:_____

### ORTHOPEDIC SURGERIES

☐ Yes ☐ No Hip Replacement
Date:_____
☐ Yes ☐ No Knee Replacement
Date:_____
☐ Yes ☐ No Shoulder Replacement
Date:_____
☐ Yes ☐ No Other Joint Replacement
Date:_____

### ENDOCRINE DISORDERS

☐ Yes ☐ No Diabetes
Type:_____
☐ Yes ☐ No Hyperthyroidism
(High Thyroid)
Treatment:_____
☐ Yes ☐ No Hypothyroidism
(Low Thyroid)
Treatment:_____

### HEMATOLOGIC (BLOOD) DISORDERS

☐ Yes ☐ No Anemia
Type:_____
☐ Yes ☐ No Leukemia
Type:_____
☐ Yes ☐ No AIDS or HIV Positive

☐ Yes ☐ No Bleeding Tendency - Do you bruise easily or bleed excessively when cut? If yes, explain:_____

☐ Yes ☐ No Have you ever had a blood transfusion? If yes, explain:
_____

**Do you have or have you had any of the following diseases or conditions? [Continued]**

## PSYCHIATRIC CONDITIONS

☐ Yes ☐ No Have you seen a psychiatrist in the last 3 years? Psychiatrist: _____ Phone: _____

## INFECTIOUS DISEASES

☐ Yes ☐ No Hepatitis
Type:_____ Date:_____

☐ Yes ☐ No Venereal Disease
Type:_____ Date:_____

☐ Yes ☐ No Tuberculosis
Type:_____ Date:_____

☐ Yes ☐ No MRSA
Date:_____

☐ Yes ☐ No VRE
Date:_____

☐ Yes ☐ No Other
Date:_____

## RENAL (KIDNEY) DISEASE

☐ Yes ☐ No Have you had a kidney infection within the last 3 years? Type: _____ Date: _____

☐ Yes ☐ No Have you had kidney surgery? Type: _____ Date: _____

## OTHER DISEASES & DISORDERS

☐ Yes ☐ No Syncope (Fainting)
Frequency:_____

☐ Yes ☐ No Liver Disease
Type:_____

☐ Yes ☐ No Cancer
Type:_____ Date:_____

☐ Yes ☐ No Radiation Therapy
Type:_____ Date:_____

☐ Yes ☐ No Glaucoma

☐ Yes ☐ No Epilepsy
Treatment:_____

☐ Yes ☐ No Arthritis
Type:_____

☐ Yes ☐ No Ulcers
Type:_____

☐ Yes ☐ No Have you had surgery or xray treatment for a tumor, growth, or other condition?

## MEDICATION - ARE YOU TAKING ANY OF THE FOLLOWING?

☐ Yes ☐ No Antibiotics or Sulfa Drugs
Type:_____ Amount:_____

☐ Yes ☐ No Anticoagulants (Blood Thinners)
Amount:_____

☐ Yes ☐ No Steroids (Cortisone)
Type:_____ Amount:_____

☐ Yes ☐ No High Blood Pressure Medication
Type:_____ Amount:_____

☐ Yes ☐ No Tranquilizers
Type:_____ Amount:_____

☐ Yes ☐ No Aspirin
Frequency:_____ Amount:_____

☐ Yes ☐ No Insulin, Tolbutomide (Orinase) or Similar Drug
Type:_____ Amount:_____

☐ Yes ☐ No Digitalis or Drugs for Heart Trouble
Type:_____ Amount:_____

☐ Yes ☐ No Nitroglycerin
Amount:

☐ Yes ☐ No Tranquilizers
Type:_____ Amount:_____

☐ Yes ☐ No Nitroglycerin
Amount:_____

☐ Yes ☐ No Oral Contraceptive or Other Hormonal Therapy
Type:_____ Amount:_____

☐ Yes ☐ No Other Drugs:
Frequency:_____ Amount:_____

☐ Yes ☐ No Other Drugs:
Frequency:_____ Amount:_____

☐ Yes ☐ No Other Drugs:
Frequency:_____ Amount:_____

☐ Yes ☐ No Other Drugs:
Frequency:_____ Amount:_____

## ALLERGIES

☐ Yes ☐ No Do you have allergies to latex?

☐ Yes ☐ No Do you have allergies to any medications or foods?
If so, please list:_____

## WOMEN ONLY

☐ Yes ☐ No Are you pregnant?
Due Date:_____

☐ Yes ☐ No Are you nursing?

## GENERAL QUESTIONS

☐ Yes ☐ No Have you ever taken the diet pill Phen-Fen?

☐ Yes ☐ No Do you use tobacco products? If so which? ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing Tobacco ☐ Other

☐ Yes ☐ No Do you consume alcohol? If so how much? ☐ Light ☐ Moderate ☐ Heavy

☐ Yes ☐ No Do you wear contact lenses?

☐ Yes ☐ No Are you employed in any situation which exposes you regularly to xrays or other ionizing radiation?

☐ Yes ☐ No Do you have any problem or condition not listed above? Please explain: _____

CONSENT: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the patient whose name appears on this Health History form and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies certain risk. I understand that responsibility for payment for dental services provided in this office for me or my dependents are due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1% to 5% finance charge (18% annually) will be added to any patient balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient or Responsible Party: _____ Date: _____

Relationship to Patient: _____