# REISMAN DENTAL GROUP
## MEDICAL HISTORY

Patient Name______________________ Nickname______________________ Age __________

Name of Physician__________________________________________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? Poor ________ Fair ________ Good ________

| HAVE YOU EVER HAD THE FOLLOWING: | YES | NO |
|---|---|---|
| 1. hospitalization for illness or injury | ❑ | ❑ |
| 2. allergic reaction to | | |
| ❑ aspirin, ibuprofen, acetomenophen | | |
| ❑ penicillin | | |
| ❑ erythromycin | | |
| ❑ tetracycline | | |
| ❑ codeine | | |
| ❑ local anesthetic | | |
| ❑ fluoride | | |
| ❑ metals (gold, stainless steel) | | |
| ❑ latex | | |
| ❑ any other medications __________ | | |
| 3. heart problems | ❑ | ❑ |
| 4. heart murmur | ❑ | ❑ |
| 5. rheumatic fever | ❑ | ❑ |
| 6. scarlet fever | ❑ | ❑ |
| 7. high blood pressure | ❑ | ❑ |
| 8. low blood pressure | ❑ | ❑ |
| 9. a stroke | ❑ | ❑ |
| 10. artificial prosthesis (i.e. heart valve or joints) | ❑ | ❑ |
| 11. anemia or other blood disorder | ❑ | ❑ |
| 12. prolonged bleeding due to a slight cut | ❑ | ❑ |
| 13. emphysema | ❑ | ❑ |
| 14. tuberculosis | ❑ | ❑ |
| 15. asthma | ❑ | ❑ |
| 16. sinus problems | ❑ | ❑ |
| 17. kidney disease | ❑ | ❑ |
| 18. liver disease | ❑ | ❑ |
| 19. jaundice | ❑ | ❑ |
| 20. thyroid or parathyroid disease | ❑ | ❑ |
| 21. hormone deficiency | ❑ | ❑ |
| 22. high cholesterol | ❑ | ❑ |
| 23. diabetes | ❑ | ❑ |
| 24. stomach or duodenal ulcer | ❑ | ❑ |
| 25. digestive disorders | ❑ | ❑ |

| | YES | NO |
|---|---|---|
| 26. arthritis | ❑ | ❑ |
| 27. glaucoma | ❑ | ❑ |
| 28. contact lenses | ❑ | ❑ |
| 29. head or neck injuries | ❑ | ❑ |
| 30. epilepsy, convulsions (seizures) | ❑ | ❑ |
| 31. viral infections and cold sores | ❑ | ❑ |
| 32. any lumps or swelling in the mouth | ❑ | ❑ |
| 33. hives, skin rash, hay fever | ❑ | ❑ |
| 34. venereal disease | ❑ | ❑ |
| 35. hepatitis (type ______) | ❑ | ❑ |
| 36. HIV / AIDS | ❑ | ❑ |
| 37. tumor, abnormal growth | ❑ | ❑ |
| 38. radiation therapy | ❑ | ❑ |
| 39. chemotherapy | ❑ | ❑ |
| 40. emotional problems | ❑ | ❑ |
| 41. psychiatric treatment | ❑ | ❑ |
| 42. antidepressant medication | ❑ | ❑ |
| 43. alcohol / drug dependency | ❑ | ❑ |

| ARE YOU: | | |
|---|---|---|
| 44. presently being treated for any illness | ❑ | ❑ |
| 45. aware of a change in your general health | ❑ | ❑ |
| 46. often exhausted or fatigued | ❑ | ❑ |
| 47. subject to frequent headaches | ❑ | ❑ |
| 48. a heavy smoker (1 pack or more a day) | ❑ | ❑ |
| 49. considered a touchy person | ❑ | ❑ |
| 50. often unhappy or depressed | ❑ | ❑ |
| 51. easily upset or irritated | ❑ | ❑ |
| 52. FEMALE - taking birth control pills | ❑ | ❑ |
| 53. FEMALE - pregnant | ❑ | ❑ |
| 54. MALE - Prostate disorders | ❑ | ❑ |

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment __________________________________________________

__________________________________________________

List any medications, herbal supplements, and or vitamins taken within the last two years__________________

__________________________________________________

__________________________________________________

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature______________________________ Date______________

Doctor's Remarks: ______________________________________________

______________________________ Doctor's Signature______________________

**OVER**

7777 Forest Lane, Suite C-104, Dallas, TX 75230 972/566-4990

# REISMAN DENTAL GROUP
## DENTAL HISTORY

Referred by ______________________________

Previous dentist ______________________________ How long ______________________________

Most recent dental exam ______________________ Most Recent dental x-ray ______________________

Most recent dental treatment ______________________

How often do you have your teeth cleaned? 3 mo._____ 4 mo._____ 6 mo._____ 1 year or longer_____

**WHAT IS YOUR IMMEDIATE DENTAL CONCERN?** ______________________________

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**PLEASE ANSWER YES OR NO TO THE FOLLOWING:**

| | YES | NO |
|---|---|---|
| 1. unhappy with the appearance of your teeth | ❑ | ❑ |
| 2. unfavorable dental experiences | ❑ | ❑ |
| 3. dental fears | ❑ | ❑ |
| 4. problems with effectiveness or bad reactions to dental anesthetic | ❑ | ❑ |
| 5. orthodontic treatment (braces) when | ❑ | ❑ |
| 6. periodontal (gum) treatment when | ❑ | ❑ |
| 7. bleeding gums | ❑ | ❑ |
| 8. avoid brushing any part of your mouth | ❑ | ❑ |
| 9. part of your mouth is sensitive to temperature | ❑ | ❑ |
| 10. sore teeth | ❑ | ❑ |
| 11. a burning sensation in your mouth | ❑ | ❑ |
| 12. difficulty swallowing | ❑ | ❑ |
| 13. an unpleasant taste or odor in your mouth | ❑ | ❑ |
| 14. dry mouth, throat, and or eyes | ❑ | ❑ |
| 15. jaw problems (temporomandibular joint) | ❑ | ❑ |
| 16. difficultly opening your mouth widely | ❑ | ❑ |
| 17. stiff neck muscles | ❑ | ❑ |
| 18. awaken with an awareness of your teeth or jaws | ❑ | ❑ |
| 19. tension headaches | ❑ | ❑ |
| 20. clench or grind your teeth | ❑ | ❑ |
| 21. jaw clicking or popping | ❑ | ❑ |
| 22. lost any teeth | ❑ | ❑ |
| 23. do you sweat or tremble a lot during examination | ❑ | ❑ |
| 24. do strange people or places make you afraid | ❑ | ❑ |

**SUPPLEMENTAL DENTURE HISTORY:**

If you are wearing a partial or complete artificial denture, please complete the following:

| YES | NO | (Please check Yes or No) |
|---|---|---|
| ❑ | ❑ | Has your present denture been relined? When ______________________ |
| ❑ | ❑ | Is your present denture a problem? Describe ______________________ |
| ❑ | ❑ | Satisfied with the appearance? ______________________ |
| ❑ | ❑ | Satisfied with the comfort? ______________________ |
| ❑ | ❑ | Satisfied with the chewing ability? ______________________ |
| | | When did you receive your first partial or complete denture? ______________________ |
| | | How long have you worn your present denture? ______________________ |

Patient's Signature ______________________________ Date ______________

Doctor's Remarks: ______________________________

______________________________ Doctor's Signature ______________________________

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