Patient Medical History

James J. Karam, D.D.S.
Excellence In Dentistry

Name______________________ Birthdate______________

	YES	NO
Are you under medical treatment now?	☐	☐
Do you use tobacco?	☐	☐
Do you use alcohol?	☐	☐
Do you use cocaine or other drugs?	☐	☐
Are you wearing contact lenses?	☐	☐
Do you take aspirin daily?	☐	☐
Have you ever been treated for depression or any emotional problem?	☐	☐

- List any medication(s) including non-prescription medicine below.
- List any hospitalization for any surgical operation or serious illness below.

Are you allergic to or have you had any reactions to the following?

	YES	NO
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

Women Only:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

DATE	MEDICATIONS	PURPOSE	DATE	SURGERY

Family Physician______________________ Office Phone______________________

Specialist______________________ Office Phone______________________

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

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis (TB)	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation/Chemo. Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Respiratory Problems	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Is there anything we should know about your health not covered by these questions?	☐	☐

Patient Dental History

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw? a) Clicking?	☐	☐
b) Difficulty in opening or closing	☐	☐
c) Difficulty in chewing?	☐	☐
Have you ever had cold sores or canker sores?	☐	☐

- Date of your last cleaning______________
- Date of your last full mouth x-rays______________

	YES	NO
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you had any orthodontic work?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
Have you ever had instruction on the care of your gums?	☐	☐
Have you ever been treated for gum disease?	☐	☐
Have you ever had an unpleasant dental experience?	☐	☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information or withheld information can be dangerous to my health.

SIGNATURE X______________________________

PATIENT, PARENT or GUARDIAN DATE