

Dr. Sheila Dobe's Medical History Form

Name _____ Date _____ / _____ / _____

Last Physical exam? _____

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

Please check YES or NO.

Heart Ailments:

Y N	Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Murmur	<input type="checkbox"/> <input type="checkbox"/> CHF	<input type="checkbox"/> <input type="checkbox"/> MVP	<input type="checkbox"/> <input type="checkbox"/> Artificial Valve	<input type="checkbox"/> <input type="checkbox"/> Pacemaker

Other Conditions:

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Liver Disease
<input type="checkbox"/> <input type="checkbox"/> Prosthetic Joint	<input type="checkbox"/> <input type="checkbox"/> GI Disorder	<input type="checkbox"/> <input type="checkbox"/> Acid Reflux	<input type="checkbox"/> <input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> <input type="checkbox"/> AIDS or ARC	<input type="checkbox"/> <input type="checkbox"/> Seizures	<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> <input type="checkbox"/> Fainting Spells	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Immune Disorders	<input type="checkbox"/> <input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> <input type="checkbox"/> Asthma/ Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> <input type="checkbox"/> Tumors	<input type="checkbox"/> <input type="checkbox"/> Cancer
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Arthritis/ Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Radiation/Chemotherapy
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Ever taken Phen-Fen	<input type="checkbox"/> <input type="checkbox"/> Ever taken Fosamax	<input type="checkbox"/> <input type="checkbox"/> Other _____

Are you taking any drugs or medication? YES NO

Medication _____	Reason _____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic or sensitive to any drugs, medication, or Latex? YES NO _____

(Women) Are you taking any birth control? _____ If not, are you pregnant? _____

Other Notes _____

I understand that if any changes occur in my health, I am to report it to the dental office as soon as possible. I have read and understand each question. I have answered all of them truthfully and to the best of my ability.

Patient's Signature _____ Date _____ / _____ / _____

Doctor/Hygienist Signature _____ Date _____ / _____ / _____

Questionnaire

Was there anything that upset you about your previous dentist or their office?

When was your last dental visit? _____

Have you ever had orthodontics (braces)? _____

Have you ever had gum treatment? _____ When? _____

Do your gums bleed? _____ When? _____

Do you have any sores, blisters, or swelling on your gums, lips, or cheeks? _____

Are your teeth sensitive to Heat, Cold, Sweets, or Other? _____

Have you ever had an injury to your face or jaw? _____

Do you ever have clicking or popping sensation? _____

Do you grind or clench your teeth? _____ Do you wear a Nightguard? _____

Do you Snore? _____ Do you wear a Snore guard? _____

What type of toothbrush do you use? Manual Electric _____

Brushing Frequency ____x day/week Flossing Frequency ____x day/week

What is your chief complaint? _____

If you could change anything about your smile, what would it be? (whiter teeth, straighter teeth...)

Would you be interested in the latest, inexpensive way of whitening your teeth? _____