Dr. Sheila Dobee'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
□ □ Murmur	□ □ CHF	□ □ MVP	□ □ Artificial Valve	□ □ Pacemaker

Other Conditions:

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

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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? _____________________

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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? ____

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

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