BARBAG DENTAL
CREATING BEAUTIFUL SMILES

Medical History

Welcome! So that we may provide you with the best possible care, please complete both sides of this form. All information is completely confidential. Thank you.

Patient_____ Date_____

Physician_____ Phone_____

Have you ever had any of the following?

Artificial Joints	**Y**	**N**	**High blood pressure**	**Y**	**N**
Anemia	**Y**	**N**	**Immunosuppressive disorders**	**Y**	**N**
Asthma	**Y**	**N**	**Kidney disease**	**Y**	**N**
Breathing problems	**Y**	**N**	**Liver disease**	**Y**	**N**
Chemical dependency	**Y**	**N**	**Low blood pressure**	**Y**	**N**
Chest pain	**Y**	**N**	**Malignancies**	**Y**	**N**
Chronic cough	**Y**	**N**	**Migraine headaches**	**Y**	**N**
Chronic Fatigue Syndrome	**Y**	**N**	**Osteoarthritis**	**Y**	**N**
Congenital heart lesion	**Y**	**N**	**Psychiatric disorders**	**Y**	**N**
Diabetes	**Y**	**N**	**Rheumatoid arthritis**	**Y**	**N**
Drug Allergies	**Y**	**N**	**Sexually Transmitted Diseases**	**Y**	**N**
Fainting spells	**Y**	**N**	**Sinus problems**	**Y**	**N**
Fibromyalgia	**Y**	**N**	**Stroke**	**Y**	**N**
Glaucoma	**Y**	**N**	**Thyroid disorders**	**Y**	**N**
Heart problems	**Y**	**N**	**Tuberculosis**	**Y**	**N**
Hepatitis	**Y**	**N**	**Ulcers**	**Y**	**N**

Are you now receiving any kind of healthcare? Yes No
Please explain_____
Have you been hospitalized or seriously ill in the last 2 years? Yes No
Please explain_____
Please give a history of all surgeries including dates_____

_____
Are you presently taking any medications? Yes No
Please list:_____
_____
Are you allergic or ever had a bad reaction to any medications? Yes No
Please list:_____

Women: Are you, or do you suspect you are pregnant? Yes No
Nursing? Yes No

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Dental History

Current Dentist_____Phone#_____

What is the reason for your visit today?_____
_____

Date of last dental visit_____Last dental cleaning_____
Last full mouth x-rays_____

How often do you brush your teeth? _____per day Floss _____per day

What other dental aids do you use (i.e. Interplak, Proxabrush, Sonicare, Rotadent, etc)_____

Are you aware of any dental problems now? _____

Have you ever had? Orthodontic Treatment Periodontal Treatment Oral Surgery

Would you like to keep your teeth the rest of your life? Yes No

Are you satisfied with your teeth's appearance? Yes No

Do you smoke? Yes No

Please circle and/or explain those that apply below

Are any of your teeth sensitive? Cold Hot Sweets Biting Chewing_____
Where? _____
Do your gums bleed or hurt? Yes No
Where or when?_____
Do you frequently notice cold sores, fever blisters, or other lesions? Yes No
Does food tend to become caught between your teeth? Where?_____

Have you noticed popping or clicking of the jaw? Yes No Pain? Yes No

Have you noticed tired or sore muscles? Neck Shoulder Jaw

Are you aware of clenching and grinding your teeth? Yes No Awake Asleep

Do you have any other concerns, or is there anything else about dental treatment you would like us to know? _____
_____