Patient Name

Charles Feldman, DDS

1502 St. Mark's Plaza #7
Stockton, Ca 95207

MEDICAL HISTORY

Medical Doctor________________________________ Phone(   )__________________Last Medical Exam Date________________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any serious illness or surgery?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medications are you taking____________
____

	Yes	No
4. Do you use tobacco?	☐	☐
5. Do you use alcohol?	☐	☐
6. Do you use cocaine or other drugs?	☐	☐
7. Do you wear contact lenses?	☐	☐

8. Are you allergic or have you ever had a reaction to any of the following (circle all that apply):
   Penicillin Erythromycin Aspirin
   Codeine Local Anesthetics (i.e. Novocain)
   Others______________________________________
   ____

9. ***Women only***

	Yes	No
A) Are you pregnant?	☐	☐
B) Are you nursing?	☐	☐
C) Are you taking birth control pills?	☐	☐

10. Do you have or have you ever had any of the following:

	Yes	No		Yes	No
High or low Blood Press.	☐	☐	Recent Weight Change	☐	☐
Heart condition such as Chest pains, Angina,	☐	☐	Taken Phen-Phen/Redux	☐	☐
Valve problem, Pacemaker	☐	☐	Lung Condition such as Asthma, Emphysema, Tuberculosis	☐	☐
Swollen Ankles	☐	☐			
Heart Attack or Stroke	☐	☐	Easily winded	☐	☐
Rheumatic Fever	☐	☐	Fainting or Seizures	☐	☐
Heart Murmur	☐	☐	Glaucoma	☐	☐
Joint Replacement	☐	☐	Hay Fever / Allergies	☐	☐
Implants	☐	☐	Venereal Disease / STDs	☐	☐
Cancer or Tumors	☐	☐	AIDS / HIV Positive	☐	☐
Radiation or Chemotherapy	☐	☐	Arthritis	☐	☐
Diabetes	☐	☐	Ulcer or Stomach Problems	☐	☐
Hepatitis or Jaundice	☐	☐	Thyroid	☐	☐
Kidney Disease	☐	☐	Liver Problems	☐	☐
Osteoporosis/Osteopenia	☐	☐	Mental/Nervous Disorders	☐	☐
Taken Bisphosonates such as Fosamax, Actonel, Bonivia, Zometa, Aredia	☐	☐	Blood Conditions such as Excessive Bleeding, Anemia, Leukemia	☐	☐

DENTAL HISTORY

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids?	☐	☐
3. Are your teeth sensitive to sweets?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores in or near your mouth?	☐	☐
6. Have you ever had head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
A) Clicking or other noises from the jaw?	☐	☐
B) Pain (joint, ear or side of face)?	☐	☐
C) Difficulty in opening or closing?	☐	☐
D) Difficulty in chewing?	☐	☐

	Yes	No
8. Do you get frequent headaches?	☐	☐
9. Do you bite your lips or cheeks?	☐	☐
10. Do you clench or grind your teeth? day / night?	☐	☐
11. Have you had any difficult extractions?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you ever had any orthodontic work (braces)?	☐	☐
14. Are you fearful of dental treatment?	☐	☐
Have you ever received instructions on the proper way		
15. to brush your teeth?	☐	☐
16. to care for your gums?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand this page to the best of my knowledge. The above questions have been accurately answered. I understand that providing inaccurate information can be dangerous to my health. I authorize the Dentist to release information including diagnosis and records of any treatment or exam rendered to me/my child during the period of dental care to third party payors and health practitioners. I authorize and request my insurance company to pay directly to the Dentist benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that I may be charged interest on balances over 30 days old. I further authorize the Dentist to run credit checks as necessary when providing credit.

X____ ____________________ ____________________

Signature of patient (or parent if minor) Date Dentist

Patient's Initials	Annual Review Date	DDS	Patient's Initials	Annual Review Date	DDS
______	______	______	______	______	______
______	______	______	______	______	______