JASON R GORDON DDS, PC
724 PELHAM PARKWAY SOUTH
BRONX, NY 10462
347-281-9444

5) DENTAL HISTORY

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? ..... Yes___ No___
Are you currently in pain? ..... Yes___ No___
Do your gums ever bleed? ..... Yes___ No___
Have you ever had difficulties associated with any previous dental work? ..... Yes___ No___
Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)? ..... Yes___ No___
Have your tonsils or adenoids been removed? ..... Yes___ No___
Do you floss on a regular basis? ..... Yes___ No___

6) MEDICAL HISTORY

Do you consider yourself in good medical health? ..... Yes___ No___
Are you taking any medications? ..... Yes___ No___
If so, please list here? _____
Are you allergic to any medications? ..... Yes___ No___
If so, please list here? _____
(Women) Are you currently pregnant? ..... Yes___ No___
If so, how many weeks? _____
(Women) Are you nursing ..... Yes___ No___
(Women) Are you taking birth control ..... Yes___ No___
Are you allergic to asprin? ..... Yes___ No___
Are you allergic to codeine? ..... Yes___ No___
Are you allergic to dental anesthetics? ..... Yes___ No___
Are you allergic to erythromycin? ..... Yes___ No___
Are you allergic to latex or rubber products? ..... Yes___ No___
Are you allergic to metals? ..... Yes___ No___
Are you allergic to penicillin? ..... Yes___ No___
Are you allergic to tetracycline? ..... Yes___ No___

Have you ever had any of the following medical problems?

Abnormal bleeding	Yes___	No___	Hepatitis	Yes___	No___
Alcohol / Drug abuse	Yes___	No___	Herpes / Fever Blisters	Yes___	No___
Anemia	Yes___	No___	High Blood Pressure	Yes___	No___
Arthritis	Yes___	No___	HIV / AIDS	Yes___	No___
Asthma	Yes___	No___	Kidney Problems	Yes___	No___
Cancer	Yes___	No___	Liver Problems	Yes___	No___
Diabetes	Yes___	No___	Low Blood Pressure	Yes___	No___
Difficulty Breathing	Yes___	No___	Pacemaker	Yes___	No___
Emphysema	Yes___	No___	Rheumatic Fever	Yes___	No___
Epilepsy	Yes___	No___	Seizures	Yes___	No___
Fainting Spells	Yes___	No___	Shingles	Yes___	No___
Frequent Headaches	Yes___	No___	Sickle Cell Disease	Yes___	No___
Glaucoma	Yes___	No___	Sinus Problems	Yes___	No___
Hay Fever	Yes___	No___	Stroke	Yes___	No___
Heart Attack	Yes___	No___	Thyroid Problems	Yes___	No___
Heart Murmur	Yes___	No___	Tuberculosis	Yes___	No___
Heart Surgery	Yes___	No___	Ulcers	Yes___	No___
Hemophilia	Yes___	No___	Venereal Disease	Yes___	No___

4) ACKNOWLEDGEMENT & AUTHORIZATION

I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE X _____ DATE _____