

Patient Name

Charles Feldman, DDS

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

MEDICAL HISTORY

Medical Doctor _____ Phone() _____ Last Medical Exam Date _____

- 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 _____

- 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
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:
High or low Blood Press.
Heart condition such as
Chest pains, Angina,
Valve problem, Pacemaker
Swollen Ankles
Heart Attack or Stroke
Rheumatic Fever
Heart Murmur
Joint Replacement
Implants
Cancer or Tumors
Radiation or Chemotherapy
Diabetes
Hepatitis or Jaundice
Kidney Disease
Osteoporosis/Osteopenia
Taken Bisphosonates such as
Fosamax, Actonel, Bonivia,
Zometa, Aredia
Recent Weight Change
Taken Phen-Phen/Redux
Lung Condition such as
Asthma, Emphysema,
Tuberculosis
Easily winded
Fainting or Seizures
Glaucoma
Hay Fever / Allergies
Venereal Disease / STDs
AIDS / HIV Positive
Arthritis
Ulcer or Stomach Problems
Thyroid
Liver Problems
Mental/Nervous Disorders
Blood Conditions such as
Excessive Bleeding,
Anemia, Leukemia

DENTAL HISTORY

- 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?

- 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

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