Medical Alert:

*Dr. Bahram Mostaghaci & Associates*

PID#_____

FOR OFFICE USE ONLY

## Private & Confidential Health History and Personal Information

Welcome to our office. Your overall health is important to us. We strive to treat all patients in a safe and effective manner, therefore we need to ask you some detailed questions related to your general health.

Today's Date____/____/____ (D / M / Y)

(Dr., Mr., Mrs., Miss., Ms.)

Name_____ (Last / First / Initial)

Date of Birth____/____/____ (D / M / Y)

**Home Phone** _____ **Bus** _____ **Cell** _____

Street Address_____ Town/City _____

Postal Code _____ E-mail _____

Occupation _____ Employer_____

Marital Status _____ Were you referred? Name of person _____

Personal Physician _____ Physician Telephone _____

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### *Account and Insurance Information*

Person responsible for account? Self____Other _____

Do you have dental insurance? No____ / Yes____Name of Company _____

Plan #_____ Cert # _____

### *Medical History*

| yes | no | | Details |
|---|---|---|---|
| ❑ | ❑ | Do you have any allergies? (medications, penicillin, latex, metals, food) | _____ |
| ❑ | ❑ | Have you ever taken penicillin / amoxicillin? | _____ |
| ❑ | ❑ | Have you ever been advised to take antibiotics prior to a dental visit? | _____ |
| ❑ | ❑ | Are you presently being treated for any medical condition? Specify: | _____ |
| ❑ | ❑ | Have you had general surgery? Type and date? | _____ |
| ❑ | ❑ | Have you ever had excessive bleeding that needed special treatment? | _____ |
| ❑ | ❑ | Do you have any history of heart disease? (congenital heart disease, chest pains, angina, infective endocarditis, heart attack) | _____ |
| ❑ | ❑ | Do you wear a pacemaker? | _____ |
| ❑ | ❑ | Do you smoke or chew tobacco? How much per day? | _____ |
| ❑ | ❑ | Are you pregnant or breast feeding? If pregnant, when is the expected due date? | _____ |

Please list all medications, non-prescription drugs and herbal supplements you are presently taking.

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***Please continue on the other side, thank you...***

Do you have or have you had any of the following?

| yes | no | | yes | no | | yes | no | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | high blood pressure | ❑ | ❑ | glaucoma | ❑ | ❑ | ADD/ADHD |
| ❑ | ❑ | heart attack | ❑ | ❑ | HIV/AIDS | ❑ | ❑ | autism |
| ❑ | ❑ | heart murmur | ❑ | ❑ | hepatitis A / B / C (circle) | ❑ | ❑ | nerve disorders |
| ❑ | ❑ | artificial heart valve | ❑ | ❑ | rheumatic fever | ❑ | ❑ | arthritis |
| ❑ | ❑ | stroke | ❑ | ❑ | scarlet fever | ❑ | ❑ | osteoporosis |
| ❑ | ❑ | high cholesterol | ❑ | ❑ | thyroid condition | ❑ | ❑ | artificial joint replacement |
| ❑ | ❑ | anemia | ❑ | ❑ | stomach ulcers/acid reflux | | (circle) | hip, knee, TMJ, other |
| ❑ | ❑ | asthma | ❑ | ❑ | kidney disease | ❑ | ❑ | cancer-type/date of diagnosis |
| ❑ | ❑ | respiratory/lung disease | ❑ | ❑ | liver disease | | | _____ |
| ❑ | ❑ | tuberculosis | ❑ | ❑ | drug/alcohol dependency | ❑ | ❑ | auto-immune disease |
| ❑ | ❑ | sinus issues | ❑ | ❑ | depression | | | _____ |
| ❑ | ❑ | diabetes: type 1 / type 2 | ❑ | ❑ | epilepsy/seizures | | | |
| | | | ❑ | ❑ | anorexia/bulimia | | | DDS Review: _____ |

Do you have any disease, condition, or illness not listed above? Please specify:

_____

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***Dental History***

When was the last time you saw a dentist?_____

Have you ever had a bad experience at the dentist?_____

How often do you brush and floss your teeth?_____

Have you had your wisdom teeth removed? If so, when?_____

Have you ever had local anesthetic (freezing)?___Yes ___No Any complications? _____

Have you had orthodontic treatment (braces)? If yes, include date of completion._____

Have you ever had any type of jaw or facial surgery?___Yes___No_____

Do you wear a grinding appliance or nightguard?_____

Do you have a history of jaw pain? _____

Do you suffer from facial pain, fibromyalgia or trigeminal neuralgia?_____

In case of emergency contact: Name_____

Phone (H)_____(W)_____

Relationship_____

The above medical and dental history is correct and consent for treatment is hereby given.

_____ _____

Patient, Parent or Guardian Date