DR DENTAL
COSMETIC & GENERAL DENTISTRY

ATTILA FRANK TALABER, D.M.D.
AFFILIATE PROFESSOR U. OF W.

MEDICAL HISTORY FORM

NAME:_____ BIRTH DATE:_____ DATE:_____

FOR THE FOLLOWING QUESTIONS, CIRCLE "YES", "NO", OR A SPECIFIC ITEM. YOUR ANSWERS ARE CONFIDENTIAL.

WHO IS YOUR PRIMARY MEDICAL PHYSICIAN?_____

WHEN WAS YOUR LAST PHYSICAL EXAM?_____

IN THE PAST 5 YEARS, HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION, OR BEEN HOSPITALIZED?
DESCRIBE:_____

LIST ALL PRESCRIPTION DRUGS, NON-PRESCRIPTION DRUGS OR VITAMINS YOU CURRENTLY TAKE:
_____

ARE YOU ALLERGIC TO:	
ASPIRIN/ACETAMINOPHEN/IBUPROFEN	YES / NO
CODEINE, DEMEROL, OTHER NARCOTICS	YES / NO
BARBITUATES, SEDATIVES OR SLEEEPING PILLS	YES / NO
PENICILLIN, ERYTHROMYCIN, TETRACYCLINE, OTHER ANTIBIOTICS	YES / NO
SULFA DRUGS	YES / NO
LATEX	YES / NO
METALS OF ANY KIND	YES / NO
LOCAL ANESTHETIC	YES / NO
OTHER ALLERGIES (LIST):_____	YES / NO

PLEASE CIRCLE "YES" OR "NO" TO INDICATE IF YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING:

HEART CONDITIONS:	
ANGINA/CHEST PAIN (UPON EXERTION)	YES / NO
ARTIFICIAL VALVE(S)	YES / NO
HEART VALVE PROBLEMS	YES / NO
HEART ATTACK/DISEASE/SURGERY	YES / NO
HEART MURMUR	YES / NO
HIGH/LOW BLOOD PRESSURE	YES / NO
PACEMAKER	YES / NO
RHEUMATIC FEVER	YES / NO
INFECTIVE (BACTERIAL) ENDOCARDITIS	YES / NO

LIVER PROBLEMS:	
LIVER DISEASE	YES / NO
HEPATITIS A, B, C, D, E	YES / NO

ONCOLOGIC PROBLEMS/TREATMENT:	
CANCER (TYPE):_____	YES / NO
CHEMOTHERAPY	YES / NO
RADIATION THERAPY	YES / NO

RESPIRATORY PROBLEMS:	
ASTHMA	YES / NO
HAY FEVER	YES / NO
SINUS PROBLEMS	YES / NO
LUNG PROBLEMS	YES / NO
SHORTNESS OF BREATH	YES / NO
TUBERCULOSIS	YES / NO
EMPHYSEMA/COPD	YES / NO

DIGESTIVE PROBLEMS:	
ACID REFLUX, G.E.R.D., HYPERACIDITY	YES / NO
ULCER(S)	YES / NO
WEIGHT LOSS	YES / NO
WEIGHT GAIN	YES / NO

JOINT PROBLEMS:	
ARTHRITIS	YES / NO
BACK PROBLEMS	YES / NO
ARTIFICIAL JOINT/JOINT REPLACEMENT	YES / NO

THYROID/PANCREAS/KIDNEY PROBLEMS:	
HYPERTHYROIDISM	YES / NO
HYPOTHYROIDISM	YES / NO
DIABETES TYPE I OR II	YES / NO
SLOW HEALING	YES / NO
KIDNEY DISEASE	YES / NO

NERVOUS PROBLEMS:	
EPILEPSY	YES / NO
DIZZINESS	YES / NO
NEUROLOGICAL DISORDER(S)	YES / NO
PHYCHOLOGICAL DISORDER(S)	YES / NO
ANOREXIA/BULIMIA	YES / NO

BACTERIAL AND VIRAL INFECTIONS/STD/STI:	
CHICKEN POX/SHINGLES	YES / NO
ORAL HERPES (COLD SORES)	YES / NO
OTHER STD/STI:_____	YES / NO

IMMUNE SYSTEM PROBLEMS:	
HIV	YES / NO
AIDS	YES / NO
AUTOIMMUNE DISEASE:_____	YES / NO

BLOOD DISORDERS:	
HEMOPHILIA	YES / NO
EXCESSIVE BLEEDING	YES / NO
ANEMIA	YES / NO
BLOOD TRANSFUSION	YES / NO

SUBSTANCE USE:	
ALCOHOL ABUSE	YES / NO
TOBACCO (SMOKING OR CHEWING)	YES / NO
MARIJUANA (SMOKING, EDIBLES, ETC.)	YES / NO
OTHER SUBSTANCES:_____	YES / NO

DO YOU HAVE, OR HAVE YOU HAD, ANY OTHER MEDICAL CONDITIONS THAT WERE NOT ADDRESSED ABOVE?

_____

DENTAL HISTORY

PLEASE CIRCLE "YES" OR "NO" AS TO WHETHER YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

ORAL TISSUES AND CONDITIONS:	
BAD BREATH/HALITOSIS	YES / NO
CANKER SORES IN MOUTH	YES / NO
GROWTHS/BLISTERS/SORES IN MOUTH	YES / NO
BLEEDING GUMS	YES / NO
PERIODONTAL (GUM) DISEASE	YES / NO

TRAUMA, TREATMENT AND APPLIANCES:	
INJURY TO FACE/JAW:_____	YES / NO
BITEGUARD/SPORTSGUARD	YES / NO
ORTHODONTICS (BRACES, INVISALIGN, ETC.)	YES / NO
ORAL SURGERY:_____	YES / NO
PARTIAL/FULL DENTURE(S)	YES / NO

TMJ SYMPTOMS AND TREATMENT:	
FREQUENT HEADACHES/NECKACHES	YES / NO
CLICKING OR POPPING JAW	YES / NO
TIRED, SORE OR PAINFUL JAW JOINT/TMJ	YES / NO
PAIN AROUND EARS/TEMPLES	YES / NO
CLENCHING OR GRINDING OF TEETH	YES / NO
TMJ TREATMENT	YES / NO
NIGHTGUARD/NTI	YES / NO

TOOTH ISSUES:	
PAIN WITH CHEWING	YES / NO
FOOD PACKING BETWEEN TEETH	YES / NO
BROKEN TOOTH OR FILLING	YES / NO
SENSITIVITY TO: HOT, COLD, SWEET, BITING	YES / NO
VAGUE ACHE/TOOTHACHE	YES / NO
SWELLING	YES / NO
LOOSE TOOTH	YES / NO

RESPIRATION RELATED:	
DRY MOUTH	YES / NO
MOUTH BREATHING	YES / NO
SNORING	YES / NO
SLEEP APNEA	YES / NO
C-PAP MACHINE	YES / NO

TREATMENT CONSIDERATIONS:	
DENTAL ANXIETY	YES / NO
EXCESSIVE GAG REFLEX	YES / NO
HARD TO GET NUMB	YES / NO
CLAUSTROPHOBIC	YES / NO
DIFFICULTY OPENING MOUTH	YES / NO

LAST VISIT TO DENTIST:_____ FOR:_____

LAST DENTAL HYGIENE APPOINTMENT:_____ WHERE:_____

DO YOU HAVE RECORDS/XRAYS AT ANOTHER OFFICE THAT WE CAN GET FOR YOU?_____

WHAT IS YOUR PRIMARY REASON FOR SEEKING DENTAL TREATMENT TODAY?

_____

WHAT DO YOU WISH YOU COULD CHANGE ABOUT YOUR TEETH?

_____

WHAT HAVE YOU LIKED ABOUT ANY DENTAL OFFICE YOU'VE VISITED IN THE PAST?

_____

_____

WHAT HAVE YOU LIKED LEAST ABOUT ANY OTHER OFFICE YOU'VE BEEN TO?

_____

_____

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS ARE CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICATIONS CHANGE, I WILL INFORM MY DENTIST AT MY NEXT APPOINTMENT.

SIGNATURE:_____ DATE:_____

PRINT NAME:_____

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