

**Sara Stock, D.D.S. & Associates**  
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*Please answer the following questions completely and thoroughly to allow our office staff to treat you and your dental needs comprehensively.*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**MEDICAL HISTORY**

- 1) Are you in good health?       Yes    No
- 2) Do you have a primary care physician?    Yes    No   Physician's Name: \_\_\_\_\_
- 3) Have you ever been hospitalized?       Yes    No   If yes, for what: \_\_\_\_\_
- 4) Do you use tobacco in any form?       Yes    No   If yes, how much: \_\_\_\_\_
- 5) (Women) Are you pregnant?           Yes    No   If yes, give due date: \_\_\_\_\_

**Do you have, or have you had, any of the following? (Check all that apply)**

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV+              | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sinus Problems    |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Congenital Heart Disease  | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Smoker            |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Convulsion                | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Diabetes (I or II)        | <input type="checkbox"/> Heart Pacemaker       | <input type="checkbox"/> Migraines             | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Pain in Joints        | <input type="checkbox"/> Tonsillitis       |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Epilepsy/Seizures         | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Venereal Disease  |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Fainting/Dizziness        | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Yellow Jaundice   |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever       |  |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            |  |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Scarlet Fever         |  |
| <input type="checkbox"/> Chest Pains            | <input type="checkbox"/> Genital Herpes            | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Shingles              |  |

Other: \_\_\_\_\_

Do you take, or have you taken, Phen-fen or Redux?    Yes    No

Do you take, or have you taken, Fosamax?               Yes    No

**ALLERGIES**

- |                                  |                                      |  |                                  |                                   |
|----------------------------------|--------------------------------------|--|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Penicillin        | <input type="checkbox"/> Codeine | <input type="checkbox"/> Percocet |
| <input type="checkbox"/> Latex   | <input type="checkbox"/> Metal       | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> None    |                                   |

Other: \_\_\_\_\_

**PLEASE COMPLETE REVERSE SIDE**

**CURRENT MEDICATIONS**

- Antibiotics/Sulfa Drugs                       Blood Pressure Medication     Digitalis/Other Heart Medications     Phen-Fen/Redux
- Antihistamines/Allergy Drugs               Blood Thinners                       Fosamax                                       Recreational Drugs
- Aspirin     Cold Remedies                       Insulin/Other Diabetes Drugs         Thyroid Medication
- Birth Control Pills                               Cortisone/Steroids                       Nitroglycerin                               Tranquilizers

Other: \_\_\_\_\_

**DENTAL HISTORY**

- 1) When was your last dental visit? \_\_\_\_\_
- 2) Have you ever pre-medicated before dental treatment?  Yes  No    If yes, please explain: \_\_\_\_\_
- 3) What is your immediate dental need? \_\_\_\_\_
- 4) Rate your smile from 1-10 (1=dissatisfied, 10=happy): \_\_\_\_\_
- 5) What aspect of your smile would you most like to correct? \_\_\_\_\_
- 6) Has anything prevented you from addressing this concern in the past? \_\_\_\_\_
- 7) Does dental treatment make you nervous?  No     Slightly     Moderately     Extremely
- 8) Have you ever had your teeth whitened in the past, including over the counter products?  Yes  No  
If yes, please explain: \_\_\_\_\_

Do you have any of the following?

- Bleeding gums                                       Loose teeth                                       Unpleasant taste/bad breath
- Sensitivity to heat                                       Burning tongue/lips                                       Sensitivity to cold
- Frequent blisters on lips/mouth                       Sensitivity to sweets                                       Swelling or lumps in the mouth
- Sensitivity to pressure                                       Bite your cheeks or lips                                       Food impaction
- Clicking or popping in the jaw                       Clenching or grinding                                       Difficulty opening or closing jaw
- Shifting teeth     Orthodontic treatment (braces)     Change in bite
- Wisdom teeth removed                                       Treated for Periodontal Disease/Surgery

Other: \_\_\_\_\_

How often do you brush? \_\_\_\_\_                      Your toothbrush is:  Soft     Medium     Hard

Do you use the following?

- Manual Toothbrush                                       Dental Floss                                       Mouthwash                                       Bottled Water
- Electric Toothbrush                                       Breath mints/Altoids     Fluoride Rinse                                       Tap Water

Other: \_\_\_\_\_

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my health status.**

\_\_\_\_\_  
**Signature of patient, parent or legal guardian**

\_\_\_\_\_  
**Date**