dental office
Ruben Mendez DDS

68100 Ramon Rd suite #A-4
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Tel: (760)483-3344
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HEALTH HISTORY

DATE ______-_______-_______ **Charts#**______________

Patient Name____ **DOB:** ___________________________

INSTRUCTIONS: Answer all questions and fill in the blank spaces when indicated. Answers to the following questions are for our records only and will be kept confidential.

Why are you **here** today? _____________________________________
When was your **last** visit to a **dental** office? ________/_________/________
When were your last dental **x-rays** taken? ________/_________/________

YES/SI	NO	
_______	_______	1. Are you in poor health?
_______	_______	2. Has there been any change in your general health within the past year?
_______	_______	3. My last physical apt. was on: ___________________________
_______	_______	4. Are you currently under the care of a physician? If so, what is the condition being treated_______________
_______	_______	5. The name and address of my physician is: ____
_______	_______	6. Have you had any serious illness or operation? If so, what was the illness or operation: __________________
_______	_______	7. Have you been hospitalized or had a serious illness within the past five years? If so, what was the problem: ____
_______	_______	8. Do you have or have you had any of the following diseases or problems:
_______	_______	A. Damaged heart valves or artificial heart valves?
_______	_______	B. Congenital heart lesions or murmurs?
_______	_______	C. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)
_______	_______	1) Do you have pain in chest upon exertion?
_______	_______	2) Are you ever short of breath after mild exercise?
_______	_______	3) Do your ankles swell?
_______	_______	4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?
_______	_______	5) Do you have a cardiac pacemaker?
_______	_______	D. Sinus trouble?
_______	_______	E. Asthma?
_______	_______	F. Allergy?
_______	_______	G. Hives or skin rash?
_______	_______	H. Fainting spells or seizures?
_______	_______	I. Diabetes?
_______	_______	1) Do you urinate (pass water) more than 6 times a day?
_______	_______	2) Are you thirsty much of the time?
_______	_______	3) Does your mouth frequently become dry?
_______	_______	J. Hepatitis, jaundice or liver disease?
_______	_______	K. Arthritis?
_______	_______	L. Inflammatory rheumatism (painful, swollen joints)?
_______	_______	M. Stomach ulcers?
_______	_______	N. Kidney trouble?
_______	_______	O. Tuberculosis?
_______	_______	P. Do you have a persistent cough or cough up blood?
_______	_______	Q. Low blood pressure?
_______	_______	R. Venereal disease?
_______	_______	S. Do you have a prosthetic hip joint prosthesis _____ implants _____bone plates ___ crews __other______

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_______ _______ 9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
_______ _______ A. Do you bruise easily?
_______ _______ B. Have you ever required a blood transfusion? If so, explain the circumstances____________________
_______ _______ 10. Do you have any blood disorder such as anemia?
_______ _______ 11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips?
_______ _______ 12. Are you taking any of the following?
If yes, indicate which.
A. Antibiotics or sulfa drugs _____________
B. Anticoagulants (blood thinners) _____________
C. Medicine for high blood pressure _____________
D. Cortisone (steroids)____________
E. Tranquilizers ______ Antihistamine ________ Aspirin ________
F. Insulin, tolbutamide (orinase) or similar drug__________
G. Digitalis or drugs for heart trouble_________ Nitroglycerin
H. Oral contraceptive or other hormonal therapy ______
I. Other drug or medicine________________________________
_______ _______ 13. Are you allergic or have you reacted adversely to any of the following: Local anesthetics?
Penicillin or other antibiotics ____________ Sulfa drugs ___________ Aspirin________ Iodine________
Barbiturates, sedatives or sleeping pills _________________ Codeine or other narcotics_____________
Are you allergic to latex or rubber products ___________________ Other allergies ___________________
_______ _______ 14. Have you taken the diet medication Redux® (Fen-Phen)? ………………..
_______ _______ 15. Do you have any disease, condition, or problem not listed above that you think I should know about?
_______ _______ 16. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?
_______ _______ 17. Are you wearing contact lenses?
_______ _______ 18. Have you ever had any of the following conditions?
Herpes ________________ Hepatitis __________ Tuberculosis ____________ HIV / AIDS__________
_______ _______ 19. Are you pregnant?
_______ _______ 20. Do you have any problems associated with your menstrual period?
_______ _______ 21. Are you nursing?
_______ _______ 22. Have you had any serious trouble associated with any previous dental treatment?
If so, explain: ____
_______ _______ 23. How often do you brush your teeth? ______________________ When? ______________________
_______ _______ 24. Do you use dental floss?
_______ _______ 25. Do your gums bleed or hurt? How often? ____
_______ _______ 26. Are any of your teeth sensitive to: Hot__________ Cold_________ Sweets _________ Pressure_________
_______ _______ 27. Does food get caught in your teeth?
_______ _______ 28. Do you have frequent headaches? __________ neck aches? ____________ shoulder aches? ________
_______ _______ 29. Do you clench or grind your teeth?
_______ _______ 30. Have you experienced any pain or soreness in the muscles of your face or around your ear?
_______ _______ 31. Does your jaw click or pop?

FOLLOW UP to Medical History by DENTIST ONLY

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____

I hereby certify that 1 have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

__________ __ _________________________ ________________________________

SIGNATURE OF **PATIENT** or **Guardian** if patient is a minor DATE