Aaron Memon DMD

Medical History

Patient Name: _____ Medical Alert:

Physician's Name: _____ Phone#_____

1. Have you had any significant medical care within the past two years? Yes No
   Describe: _____
2. Have you taken any medication or drugs during the past two years? Yes No
   List: _____
3. Are you currently taking any medication, drugs, pills, or herbal remedies, including regular dosages of aspirin? Yes No
   List: _____
4. Have you ever taken prescription medication for weight loss? Yes No
   If yes, did you take any of the following: Fen-Phen Pondimen Redux other
   If yes to any of the above, did you have a medical exam for heart issue? Yes No
5. Have you ever taken bone loss prevention drugs such as: Fosamax, Actonel, Boniva or other similar drugs? Yes NO List: _____
6. Have you been a patient in the hospital during the past five years? Yes No
   Describe: _____
7. **Indicate which of the following you have had, or have at present. Circle Yes or No**

Heart (surgery,disease,attack):	Yes No	Ulcers:	Yes No	Hepatitis A B C (circle)	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	Cold Sores/Fever blister	Yes No
High/Low Blood Pressure	Yes No	Contact Lenses	Yes No	Blood Transfusion	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Hemophilia	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Sickle Cell Disease	Yes No
Pacemaker	Yes No	Tuberculosis	Yes No	Bruise Easily	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Liver Disease/Jaundice	Yes No
Arthritis/ Rheumatism	Yes No	Hay Fever/Allergy	Yes No	Neurological Disorders	Yes No
Swollen Ankles	Yes No	Latex Sensitivity	Yes No	Epilepsy or Seizures	Yes No
Stroke	Yes No	Sinus Trouble	Yes No	Fainting or Dizzy Spells	Yes No
Diet	Yes No	Radiation Therapy	Yes No	Nervous/Anxious	Yes No
Artificial Joints	Yes No	Chemotherapy	Yes No	Psychiatric Care	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Psychological Care	Yes No

8. Are you aware of having any allergic (or adverse) reaction to any substance or medication? Yes No
9. Have you lost or gained more than 10 pounds in the past year? Yes No
10. Do you have or have you had any disease, condition, or problem not listed? Yes No
    please list: _____
11. Women: Are you pregnant or think you could be pregnant? Yes ____ Months No Nursing? Yes No

What is the reason for your visit today? _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (interplak, toothpick, etc.) _____
Do you have any other Dental problems now? Yes No
If yes, please describe_____
Have you ever been told to take a pre-medication prior to dental treatment? Yes No

Are any of your teeth sensitive to:		**Have you ever had:**	
Hot or cold	Yes No	Orthodontic Treatment	Yes No
Sweets	Yes No	Oral Surgery	Yes No
Gums bleed or hurt?	Yes No	A bite plate or mouth guard	Yes No
Chewing	Yes No	Periodontal Treatment	Yes No
Bad Mouth Odor or Taste	Yes No	Your teeth ground/bite adjusted	Yes No
Cold Sores/Blisters	Yes No		

Have you experienced:			
Clicking or popping of the jaw	Yes No	Head, neck or shoulder aches	Yes No
Sore muscles	Yes No	Difficulty in chewing	Yes No
Difficulty in opening mouth	Yes No	Pain (joint, ear, side of face)	Yes No

Do You:

Clench or grind your teeth while awake or asleep?	Yes No
Bite your lips or cheeks regularly?	Yes No
Hold foreign objects with your teeth?	Yes No
Mouth breathe while awake or asleep?	Yes No
Have tired jaws, especially in the morning?	Yes No
Snore or have any other sleeping disorders?	Yes No
Smoke/ chew tobacco?	Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health and medication.

Patient/Guardian Signature _____ Date_____