ROBERT H. WALDMAN D.D.S.

DENTAL HISTORY

PATIENT NAME:___________________________AGE:_______ TODAY'S DATE:__________
Reason for visit:____

When was your last dental visit?	Previous Dentist?	Reason for leaving:

Have you ever had problems with Dental Treatment: Y N Describe:____
Do your jaw joints ache, pop or click? Currently Y N
Do you chew on only one side of your mouth? Y N
Do you have any lumps or sore areas around your mouth? Y N
Do you have difficulty swallowing? Y N
Do you experience hoarseness? Y N
Are your teeth sensitive to:
Hot Cold Sweets Biting Chewing Clenching Grinding

Do you brush daily? Y N How many times a day?______
Do you floss? Y N How often? ________________
Do your gums feel tender or swollen? Y N
Do your gums bleed when brushing? Y N
Do your gums bleed when flossing? Y N
Do you still have your wisdom teeth? Y N

Past Dental Treatment:
Braces-When:____ Root Canals-When: _____ Gum Surgery-When:_____ Oral Cancer-When:_____
Jaw/TMJ (guard therapy)-When:______ Dentures/Removable appliances-Age:____
Please add anything else you feel is important:____
____

MEDICAL HISTORY

Yes (Y), No (N), Unsure (U)

Do you require antibiotics for dental treatment? Y N U
Reason: ____
Joint Replacements:_______________________________
Do you take medication for osteoporosis (Bisphosphonate) ie:Fosamax, Boniva, Zometa? Y N U

WOMEN:
Do you take birth control medication? Y N U
Are pre-menopausal? Y N U Post menopausal? Y N U
Are you pregnant? Y N U Are you nursing? Y N

Your current physical health is: Good Fair Poor
Are you currently Under the care of a physician? Y N
Please explain:____
Physician's name:____
Phone:_______________________ Email:__________________________
Last Visit:_________________________
Pharmacy Name:___________________Phone:______________________
Kaiser ID:____
Medical Insurance ID:____

Medical Conditions: Current (C), Past (P), Never (N), Yes (Y), No (N), Unsure (U)

C P N	Alcohol Abuse	C P N	Diabetes	C P N	Pace Maker	C P N	Low Blood Pressure	C P N	Vertigo(Spinning Sensation)
C P N	Recreation Drugs	C P N	Abnormal Bleeding	C P N	Fainting Spells	C P N	High Blood Pressure	C P N	Frequent Headaches
C P N	Tobacco in any form	C P N	Anemia	C P N	Artificial Heart Valves	C P N	Arthritis	C P N	Seizures
C P N	Asthma	C P N	Blood Transfusion	C P N	Heart Attack	C P N	Hepatitis	C P N	Epilepsy
C P N	Difficulty Breathing	C P N	Hemophilia	C P N	Heart Murmur	C P N	HIV/AIDS	C P N	Stroke
C P N	Emphysema	C P N	Depression	C P N	Heart Surgery	C P N	Ulcers	C P N	Sinus Problems
C P N	Persistent Cough	C P N	Eating Disorder	C P N	Congenital Heart Defect	C P N	Colitis	C P N	Sleep Apnea
C P N	Tuberculosis(TB)	C P N	Anxiety	C P N	Mitral Valve Prolapse	C P N	Glaucoma	C P N	Snoring
C P N	Hoarseness/Swallow	C P N	Psychiatric Care	C P N	Afib/Vfib	C P N	Kidney Problems	C P N	**Family History**:
C P N	Sore Throat	C P N	Tonsillitis	C P N	Blood Clot(s)	C P N	Liver Disease	Y N U	*Gum Disease
C P N	Swollen Glands	C P N	Chicken Pox	C P N	Irregular Heart Beat	C P N	Lupus	Y N U	*Dentures
C P N	Cancer	C P N	Shingles	C P N	Rheumatic Fever	C P N	Steroid Therapy	Y N U	*Heart Disease
C P N	Chemotherapy	C P N	Fever blisters	C P N	Scarlet Fever	C P N	Osteoporosis	Y N U	*Diabetes
C P N	Radiation Treatment	C P N	Herpes	C P N	Hormone Replacement Therapy	C P N	Sickle Cell Disease	Y N U	*Cancer
		C P N	Venereal Disease	C P N	Thyroid Disease	C P N	Seasonal Allergies	Y N U	*Stroke

Please list any medical conditions and surgeries you may have experienced or were hospitalized for or any information not listed above:
____

***Please list any prescription AND over the counter medication you are currently taking? (If more than 5 please ask for addition** paper)*
1.___________________2.____________________3.____________________4.______________________5.____________________

Circle Y(yes) N(no) if you are allergic to the following:

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry/Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please List anything additional that causes allergic reactions:____

Do you consume Alcohol: Y N If YES: What type:__________________________How many drinks per Day____ Week______

If you use Tobacco: Do you Chew? Y N How often:________Do you Smoke: Y N How often:_______Do you use Vapor? Y N How often?_____

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I AGREE TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

Signature:(Parent if minor)___________________________________ Date:________ Staff_____________________________________ Date:______

MEDICAL HISTORY UPDATE: I have read my medical history and confirmed that it states past and present medical conditions.

Patient:____ Date:____	Patient:____ Date:____	Patient:____ Date:____	Patient:____ Date:____	Patient:___ Date:____
Staff:______ Date:_____	Staff:_______ Date:____	Staff:_____ Date:____	Staff:______ Date:____	Staff:______ Date:_____