MOJGAN HASHEMI, D.D.S.

Name: ______________________________

PATIENT HEALTH HISTORY

Date of last Medical Exam: ____________________

How would you describe your health? __Excellent __ Very Good __ Good __ Fair __Others: Please describe? ____________________

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Do you have a Medical Physician? __No __Yes: Name of Physician ________________________ **Tel. #** ____________________

1. **Are you now or have you been under the care of a physician within the past five years? __No __Yes If so, why?** ________________
2. **Have you had any major surgery or hospitalization? __No __Yes. Describe:** ________________________ **When:** __________
3. **Are you now or have you recently been taking any medication? If so, for what?** ______________________________
4. **Are you taking a bisphosphonate medication for osteoporosis (Fosamax, Actonel, Boniva, or IV Bisphosphnates)?__No __Yes**
5. **Are you allergic to or have any reactions to any of the following:**

	Y	N		Y	N		Y	N
Local Anesthetics (e.g. Novocain)			Aspirikn			Iodine		
Penicillin or any other antibiotics			Codeine			Latex rubber		
Sulfa Drugs			Barbiturates			Others (please list)		
Any metals(e.g. nickel, mercury)			Sedatives					

6. **WOMEN ONLY:**

	Y	N
a) Are you pregnant or think you may be pregnant?		
b.) Are you nursing?		
c.) Are you practicing birth control medication?		

7. **DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:**

	Y	N		Y	N		Y	N		Y	N
Heart Attack			Joint Replacement/Implant			Epilepsy or Seizures			Gonorrhea		
Heart Failure			Kidney Trouble			Glaucoma			Cold Sores		
Heart Surgery			Ulcers			Pain in Jaw Joints			Genital Herpes		
Heart Disease			Arthritis			Aids or HIV Infection			Fainting/Dizzy Spells		
Angina Pectoris			Emphysema			Liver Disease			Nervousness		
Heart Murmur			Tuberculosis			Hepatitis A (infectious)			Psychiatric Treatment		
High Blood Pressure			Asthma			Hepatitis B (serum)			Sickle Cell Disease		
Rheumatic Fever			Hay Fever/Allergies			Hepatitis C			Bleeding Gums		
Congenital Heart Defect			Sinus Trouble			Yellow Jaundice			Tooth Pain		
Scarlet Fever			Diabetes			Blood Transfusion			Bad Breath		
Artificial Heart Valve			Thyroid Disease			Drug Addiction			Chronic Headaches		
Mitral Valve Prolapse			Radiation Therapy			Hemophilia			Chronic Neck Aches		
Heart Pace Maker			Chemotherapy			Syphilis			Cosmetic Surgery		
Stroke			Cancer			Leukemia			Cortisone Medicine		
Others not listed:											

PATIENT DENTAL HISTORY

Name of previous Dentist and Location: ________________________________ **Date of Last Exam:** __________

	Y	N		Y	N
1. Do your gums bleed while brushing or flossing?			8. Do you have frequent headaches?		
2. Are your teeth sensitive to hot or cold liquids/foods?			9. Do you clench or grind your teeth?		
3. Are your teeth sensitive to sweet or sour liquids/foods?			10. Do you bite your lips or cheeks frequently?		
4. Do you feel pain to any of your teeth?			11. Have you ever had any difficulty with extractions in the past?		
5. Do you have any sores or lumps in or near your mouth?			12. Have you had any orthodontic treatment?		
6. Have you had any head, neck or jaw injuries?			13. Have you ever had any prolonged bleeding following extractions?		
7. Have you ever experienced any of the following Problems in your jaw? a) Clicking			14. Do you wear dentures or partials? If yes, date of placement:		
b) Pain (joint, ear, side of face)			15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
c) Difficulty in opening or closing			16. Do you like your smile?		
d) Difficulty in chewing					

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature of Patient/Parent or Guardian: ________________________________ **Date** __________

Doctor's Signature: ________________________________ **Date** __________

Doctor's Comments: ________________________________