Ramin Razavi , DMD, MS
Effective: April 15, 2003

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Ramin Razavi, DMD, MS

DENTAL HISTORY

Name:_____

Date of Birth: _____ Today's date:_____

Reason for visit:_____

When was your last dental visit?_____

How often do you brush your teeth? _____

What texture brush do you use? 0 Soft 0 Medium 0 Hard

	YES	NO
Do your gums bleed while brushing?	0	0
Do your gums bleed while flossing?	0	0
Do you feel pain to any of your teeth when brushing or flossing them?	0	0
Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	0	0
Have you noticed any loosening of your teeth?	0	0
Does food tend to become caught between your teeth?	0	0
Do you have any sores or lumps in or near your mouth?	0	0
Have you ever experienced any of the following problems in your jaw:		
Clicking	0	0
Pain (joint, ear, side of face)	0	0
Difficulty in opening or closing	0	0
Difficulty in chewing	0	0

	YES	NO
Have you had any head, neck, or jaw injuries?	0	0
Do you have frequent headaches?	0	0
Do you clench or grind your teeth while awake or asleep?	0	0
Do you bite your lips or cheeks frequently?	0	0
Have you ever had:		
Orthodontic treatment?	0	0
Oral surgery?	0	0
Gum treatment?	0	0
Your teeth ground or the bite adjusted?	0	0
Or worn a bite plane appliance?	0	0
Are you satisfied with the appearance of your teeth?	0	0
Have you ever had an upsetting experience in a dental office?	0	0
Does dental treatment bother you?	0	0