Mission Dental Implant Center
AL MANESH, D.M.D., INC., PERIODONTIST
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Reason for This Visit _____

MEDICAL AND DENTAL HISTORY

Date of last complete physical _____ Date of last Dental Cleaning _____

HAVE YOU EVER HAD:	Yes	No
Hepatitis or Liver Disease		
Epilepsy, convulsions or seizures		
Rheumatic Fever		
Kidney or Bladder Disease		
Diabetes		
Tuberculosis or Emphysema		
Heart Trouble		
Heart Murmur		
High/Low Blood Pressure		
Shortness of Breath or Swollen Ankles		
Chest Pains		
Allergies		
Cancer		
Chemotherapy/Radiation Therapy		
Stroke		
Venereal Disease		
Surgery within last 5 years		
Glaucoma		
Contact Lenses		
Arthritis or Rheumatism		
Psychiatric Treatment		
Thyroid Trouble		
Ulcers		
Sinus Problems		
Asthma or Hay Fever		
Anemia		
Any Prosthetic Devices		
Heart Valve		
Hip		
Other		
An unfavorable reaction to a drug		
Such as: Aspirin		
Barbiturates		
Anesthetics		
Antibiotics eg Penicillin		
Sulfa drugs		
Demerol		
Codiene		
Valium		
Any serious illness not listed		

_____

_____

HAS:	Yes	No
A member of your family had diabetes? Who? _____		
A member of your family had heart disease, low/high blood pressure? Who? _____		
ARE YOU:		
Presently under the care of a physician		
Taking any medication now		
Or within the past year		
Such as: Antibiotics		
Anticoagulants		
Cortisone		
Tranquilizers		
Medication for high blood pressure		
Thyroid tablets		
Mood elevators eg Elavil		
Aspirin		
Other _____ _____		
Allergic to dental anesthetic		
Subject to frequent urination		
Often thirsty		
Easily exhausted or fatigued		
Subject to frequent headaches		
Slow in healing		
In good health now		
A mouth breather		
Satisfied with the appearance of your teeth		
Often unhappy or depressed		
Do you have prolonged bleeding after injury or tooth extraction?		
Do you ever have sore or popping joints?		
Do you clench your teeth day or night?		

HAVE YOU:	Yes	No
Ever been told you have gum trouble		
Ever had trench mouth		
Ever been treated for Periodontal disease (Pyorrhea)		
Ever had Orthodontic treatment		
Had shifting of any teeth		
Had instructions on how to control plaque in your mouth		
Had immediate relatives lose all their natural teeth		
DO YOU:		
Ever have bad breath		
Ever have sore teeth		
Ever have gum abcesses		
Have unpleasant tastes in your mouth		
Have bleeding gums		
Have tooth sensitivity		
to heat		
to cold		
to sweets		
Have X-Rays in last year		
Awaken with sore jaws		
Drink coffee		
Smoke - What and how much _____		
Have fever blisters frequently		
Have mouth ulcers frequently		
Bruise easily		
Have any fear of dental treatment		
Want to keep your teeth		
yes, no matter how much trouble		
yes, if it's not too much trouble		
don't know		
don't care		
IF FEMALE, ARE YOU NOW:		
Pregnant		
Taking birth control pills		
Through menopause		
Taking hormone medication		

Please add anything you feel is important:

_____

_____

_____

_____

_____

_____

This is a complete review of all medical history, medical conditions and medications as of _____

Dentist's Signature _____ Patient's Signature _____