Mayers & Nakisbendi Dental Associates
Michael P. Mayers, DMD • Leyla Z. Nakisbendi,DMD

PATIENT MEDICAL HISTORY

Patient Name **Date of Birth**

Primary Care Physician Name **Phone number** **Date of last Exam**

	Yes	No
1. Are you receiving any medical treatment?	___	___
2. Have you ever been hospitalized for any illness or surgery within the last 5 years? If yes, please explain ______		
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication are you taking? ______		
4. Do you use tobacco?	___	___
5. Do you use controlled substances?	___	___

Are you allergic to or have you had any reactions to the following?

	Yes	No		Yes	No	Women Only	Yes	No
Local Anesthetics (e.g novocaine)	___	___	Iodine	___	___	Are you pregnant?	___	___
Penicillin or any other antibiotics	___	___	Sulfa Drugs	___	___	Are you nurseing?	___	___
Barbiturates	___	___	Sedatives	___	___	Are you taking ?	___	___
Aspirin	___	___	Any metals:	___	___	Oral Contraception?	___	___
Latex/ Rubber	___	___	e.g Nickle, Mercury ect.	___	___			
Other: ______								

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High blood pressure	___	___	Heart Disease	___	___	Chest pain	___	___
Heart Attack	___	___	Cardiac Pacemaker	___	___	Easily Winded	___	___
Rheumatic Fever	___	___	Heart Murmur	___	___	Stroke	___	___
Swollen ankles	___	___	Angina	___	___	Hay fever/ Allergies	___	___
Fainting/ Seizures	___	___	Frequently Tired	___	___	Tuberculosis	___	___
Asthma	___	___	Emphysema	___	___	Radiation Therapy	___	___
Low blood pressure	___	___	Cancer	___	___	Glaucoma	___	___
Epilepsy	___	___	Arthritis	___	___	Recent Weight Loss	___	___
Leukemia	___	___	Joint Replacement	___	___	Liver disease	___	___
Diabetes	___	___	Hepatitis/ jaundice	___	___	Heart problems	___	___
Kidney Disease	___	___	Anemia	___	___		___	___
AIDS/ HIV infection	___	___	Respiratoty issues	___	___	Mitral valve prolapse	___	___
Thyroid Problem	___	___	STD	___	___	Other ______		

Patient Dental History

Name of Previous Dentist ______ **Date of last exam** ______

	Yes	No		Yes	No
Do your gums bleed while brushing/ flossing?	___	___	Do you have frequent Headaches?	___	___
Sensitivity to hot or cold liquids/ foods?	___	___	Do you clench or grind your teeth?	___	___
Sensitivity to sweet or sour liquids or foods?	___	___	Do you bite your lips or cheeks?	___	___
Do you feel pain in any of your teeth?	___	___	Have you had difficult extractions?	___	___
Do you have any sores or lumps in or near your mouth?	___	___	Prolonged bleeding after an extraction?	___	___
Have you had any head, neck, or jaw injuries?	___	___	Have you had orthodontic treatment?	___	___
Problems with your jaw?			Do you wear dentures or partials?	___	___
Clicking	___	___	Have you received hygeine instruction regarding oral care?	___	___
Pain	___	___			
Difficulty opening or closing	___	___	Are you satisfied with the appearance of your teeth?	___	___
Dificulty chewing	___	___			

I certify that the above information is complete and accurate. I authorize the dentist to preform diagnostic procedures and treatment as is necessary for proper dental care.

Patient signature Date

Reviewed by Dentist/Hygienist Date