

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any operations? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Have seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have.

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |
- Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

- Yes No Are you presently in any dental pain? _____
 - Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
 - Yes No Have you ever lost or chipped any teeth? _____
 - Yes No Have there been any injuries to face, mouth, or teeth? _____
 - Yes No Is any part of your mouth sensitive to temperature? Where? _____
 - Yes No Is any part of your mouth sensitive to pressure? Where? _____
 - Yes No Do your gums bleed when you brush? _____
 - Yes No Do you have any type of thumb or tongue habit? _____
 - Yes No Are you a mouth breather? _____
 - Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
 - Yes No Are you aware of your jaw clicking or popping? _____
 - Yes No Are you aware of clenching your teeth during the day? _____
 - Yes No Have you ever been told that you grind your teeth? _____
 - Yes No Do you have "tension" headaches? _____
 - Yes No Have you ever experienced chronic ringing in your ears? _____
 - Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
 - Yes No Are you aware that some appointments will be during school/work hours? _____
- Please list some hobbies or interests _____
- Female Patients only:
- Yes No Are you pregnant? _____
 - Yes No Has menstruation started? _____

BENEFITS

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Casaus to perform a complete dental evaluation.

Signature: _____ Date: _____