



BAY COSMETIC DENTISTRY
 JEFFREY V. SCHROEDER, D.D.S.
 RICHARD P. SABLE, D.D.S.
 MICHAEL R. SCHER, D.D.S.

PATIENT MEDICAL HISTORY

NAME _____ **DOB** ____ / ____ / ____
 FIRST MIDDLE LAST

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health issues that you may have or medication that you may be taking could have an important interrelationship with the dentistry that you will be receiving. Your responses to the following questions will assist us in providing the best care.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health within the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Date of your last physical exam _____ / ____ / ____ | | |
| 4. Physician's Name _____
Address _____
Phone Number _____ | | |
| 5. Are you currently under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been hospitalized for any surgical operation or serious illness?
If YES, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you taking any medications including non-prescription medications?
If YES, what medications are you taking: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had any abnormal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you bruise easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever required a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had recent unexplained weight loss or gain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you or have you used controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any disease or condition not listed that you believe we should be aware of? | <input type="checkbox"/> | <input type="checkbox"/> |
| WOMEN ONLY | | |
| 20. Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

If you could change anything about your smile, what would it be? _____



BAY COSMETIC DENTISTRY
 JEFFREY V. SCHROEDER, D.D.S.
 RICHARD P. SABLE, D.D.S.
 MICHAEL R. SCHER, D.D.S.

PATIENT MEDICAL HISTORY

NAME _____ **DOB** ____ / ____ / ____
 FIRST MIDDLE LAST

	YES	NO		YES	NO
Are you allergic to or have you had reactions to:					
Local anesthetics like novocaine.....	<input type="checkbox"/>	<input type="checkbox"/>	Hives or skin rash.....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizzy spells.....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>
Asprin.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Any metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or rheumatism.....	<input type="checkbox"/>	<input type="checkbox"/>
Latex / Rubber.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement or implant.....	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please List) _____			Stomach ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had the following:					
Rheumatic heart disease or rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart defect or murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble, heart attack, or angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Cough that produces blood.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain / Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy (Cancer, Leukemia)	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
High/Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of feet, ankles, hands.....	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness.....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Jaundice, or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Tumors.....	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Mental health care.....	<input type="checkbox"/>	<input type="checkbox"/>
Lung and/or breathing problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Back problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Chemical dependency.....	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores / Fever blisters.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
			Hypoglycemia.....	<input type="checkbox"/>	<input type="checkbox"/>

Reason for this visit? _____
 When was your last dental visit? _____
 How often did you visit the dentist before then? _____
 Previous dentist (Name & Location) _____
 Have you had a complete series of dental X-Rays taken? YES NO
 If YES, when & where? _____



BAY COSMETIC DENTISTRY
 JEFFREY V. SCHROEDER, D.D.S.
 RICHARD P. SABLE, D.D.S.
 MICHAEL R. SCHER, D.D.S.

PATIENT MEDICAL HISTORY

NAME _____ **DOB** ____ / ____ / ____
 FIRST MIDDLE LAST

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Is your drinking water fluoridated? YES NO

	YES	NO		YES	NO
Do your gums bleed while brushing or flossing?...	<input type="checkbox"/>	<input type="checkbox"/>	Do you frequently bite your lips or cheeks?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquid/food?	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any loosening of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour liquid/food?	<input type="checkbox"/>	<input type="checkbox"/>	Does food tend to become caught in your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had periodontal treatment (gums)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Ever worn a bite plate or other appliance?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any difficult extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced any of the following problems in your jaw:			Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking?.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement: ____ / ____ / ____		
Pain (joint, ear side of face)?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received oral hygiene instructions regarding the care of your teeth & gums?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing?.....	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing?.....	<input type="checkbox"/>	<input type="checkbox"/>			
Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>			
Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>			

AUTHORIZATION & 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 records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services rendered on my behalf or my dependents.

Signature of patient (Parent/Guardian if minor) _____

Date _____

DOCTOR'S COMMENTS _____

Signature: _____ Date _____