JOHN H. SATTAR, DDS
FAMILY DENTISTRY

Patient Name: _____ Today's Date: _____
Home Address: _____ Date of Birth: _____
_____ Social Security No: _____
Cell Phone: _____ Home Phone: _____
Work Phone: _____ Email: _____

Patient Medical History

Physician:_____ Office Phone:_____ Date of Last Exam: _____

	YES	NO
1)Are you under Medical Treatment Now?	☐	☐
2)Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3)Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4)Do you use tabacco?	☐	☐
5)Do you use alcohol, cocaine or other drugs?	☐	☐
6) Are you wearing contact lenses?	☐	☐

7)Are you allergic to or have you had any reactions to the followings?	YES	NO
Local Anesthetics (e.g novocaine)	☐	☐
Penecillin or Other Antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Others	☐	☐
8)Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

Do you or you have you had any of the following?	YES	NO
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting/ Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/ Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐
Cardic Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement/Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Trasmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Others	☐	☐

_____
_____

Patient Dental History

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensetive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensetive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clickings?	☐	☐
b) Pain(joint, ear, side or face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheecks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

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.

SIGNATURE :_____ _____
PATIENT, PARENT OR GUARDIAN DATE