VAHAN GRIGORYAN, DDS, INC. # Adult Health / Dental History **Date:**

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient's Name:	SSN or PT ID:	Date of Birth:
Address: PO Box or Mailing Address	City	State Zip Code
Occupation:	Height:	Weight:
Phone: ( ) Home ( ) Work	Emergency Contact	Sex: M ☐ F ☐ Non binary ☐
Are you completing this form for another person? ☐ Yes ☐ No	If yes, name?	If yes, relationship?

Do you have any of the following diseases or problems: **(check DK if you don't know the answer to the question)**	Yes	No	DK
1. Active Tuberculosis?	☐	☐	☐
2. Persistent cough greater than a three-week duration?	☐	☐	☐
3. Cough that produces blood?	☐	☐	☐
4. Exposed to anyone with Tuberculosis?	☐	☐	☐

If you answer yes to any of the four items above, please STOP and return this form to the receptionist.

Please list the name and phone number of your physician: Physician _____ Phone _____-_____-_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Allergies - Are you allergic to or have you had a reaction to:

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Animals	☐	☐	☐	Food	☐	☐	☐	Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐	Hay fever/seasonal	☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐
Barbiturates/sedative/sleeping pills	☐	☐	☐	Iodine	☐	☐	☐	Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐	Latex (rubber)	☐	☐	☐	Other:	☐	☐	☐

If Yes or other, please explain: _____

Medications:	Yes	No	DK
Are you taking, or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____ _____	☐	☐	☐

Health History:	Yes	No	DK		Yes	No	DK
Do you wear contact lenses?	☐	☐	☐	*Do you use controlled substances (drugs)?*	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip knee, elbow, finger) replacement? If yes, Date: _____ Any complications?_____ _____	☐	☐	☐	Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? Circle one .**VERY / SOMEWHAT / NOT INTERESTED**	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease, Multiple Myeloma, or Cancer?	☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours?_____	☐	☐	☐

Health History: (continued):	Yes	No	DK		Yes	No	DK
Are you in good health?	☐	☐	☐	Have you had a serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	☐
Are you now under the care of a physician? Physician Name:_____ Phone Number:_____ Address:_____	☐	☐	☐	*If yes, what was the illness or problem?* _____ _____ _____	☐	☐	☐
Has there been any change in your general health within the past year? If yes, what condition is being treated? _____	☐	☐	☐	Date of last physical exam:_____	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? *Date Treatment began:* _____	☐	☐	☐	**WOMEN ONLY Are you:** Pregnant? Number of weeks?_____ Taking birth control or hormone replacement? Nursing?	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

Health History: *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:_____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus	☐	☐	☐
Erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Chronic pain	☐	☐	☐

	Yes	No	DK
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/ persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting or Dizziness	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐

	Yes	No	DK
Persistent swollen glands in neck	☐	☐	☐
Severe headaches or migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted Disease	☐	☐	☐
Excessive urination	☐	☐	☐
Swollen Ankles	☐	☐	☐
Shortness of Breath	☐	☐	☐
Bleeding Problems	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Diarrhea/Constipation /Blood in stool	☐	☐	☐
Vomiting /Nausea	☐	☐	☐
Difficulty Urinating	☐	☐	☐
Ringing in the Ears	☐	☐	☐
Blurred Vision	☐	☐	☐
Skin Disease	☐	☐	☐
Seizures	☐	☐	☐

	Yes	No	DK		Yes	No	DK
Family History Problems? _____ _____	☐	☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
Do you have any disease, condition, or problem not listed above that you think I should know about? _____ _____	☐	☐	☐	Name of physician or dentist making recommendation: _____ Phone : (_____)_____-_____			

What is the reason for your dental visit today? _____

How do you feel about your smile?_____

How often do you brush your teeth?_____ How often do you floss?_____

How often do you visit the dentist?_____ Date of your last dental exam:_____

Name of former Dentist?_____ Date of last dental x-rays:_____

Dental History:	*Yes*	*No*	*DK*		*Yes*	*No*	*DK*
Do your gums bleed when you brush or floss?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
Do you have any loose teeth?	☐	☐	☐	Do you suffer from bad breath?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear dentures or partials?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐	Do you participate in active recreational activities?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐	Are you currently experiencing dental pain or discomfort	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐	On a scale of 1 -10 how would you rate your pain?			
If yes, how often?				☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐			
Circle one: **DAILY / WEEKLY / OCCASIONALLY**				1 2 3 4 5 6 7 8 9 10			

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For Completion by Dentist:

Review of Systems: (HEENT, GI, Resp, GU, MS, Endo, Skin, Neuro, Hemo)

_____

_____

_____

_____

_____

Contraindications: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

_____

_____

Signature of Dentist **Reviewed by:** _____ **Date:**_____

Medical History Review:

1	Patient Signature:		Date:	
	Reviewing Dentist Signature:		Date:	
2	Patient Signature:		Date:	
	Reviewing Dentist Signature:		Date:	
3	Patient Signature:		Date:	
	Reviewing Dentist Signature:		Date:	
4	Patient Signature:		Date:	
	Reviewing Dentist Signature:		Date:	