Arlene R. Kubit, D.M.D.

Member of the American College of Prosthodontists

Medical History Date_____

Name _____
Street address _____
City _____State _____ Zip code _____
Home phone _____ Business phone _____

Employed by _____
Address of employer _____

Social security no. _____ Date of birth _____
Height _____ Weight _____ Marital status S__ M__ D__ W__
Spouse name _____
Spouse employed by _____ Business phone _____

Your dental insurance _____ ID# _____
Your medical insurance _____ ID# _____
Spouse dental insurance _____ ID# _____
Spouse medical insurance _____ID# _____

Who referred you to our office? _____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health? …….. Yes No
Has there been any change in your general health in the past year?……. Yes No
My last physical exam was on _____
Are you now under the care of a physician? …….. Yes No
If so, what is the condition being treated? _____
The name and address of my physician is _____
_____
Are you taking any drugs or medicine? ……. Yes No
If so, what? _____
Are you taking any of the following?

- Antibiotics or sulfa drugs …….. Yes No
- Anticoagulants (blood thinners) …… Yes No
- Medicine for high blood pressure …….. Yes No
- Cortisone (steroids) …… Yes No
- Tranquilizers …….. Yes No
- Antihistamines …….. Yes No
- Aspirin …… Yes No
- Insulin, tolbutamide (Orinase) or similar drug …….. Yes No
- Digitalis or drug for heart trouble …….. Yes No
- Nitroglycerin ……..… Yes No
- Oral contraceptive or other hormonal therapy …….. Yes No
- Thyroid medication …….. Yes No
- Other

Arlene R. Kubit, D.M.D.

Member of the American College of Prosthodontists

Have you had any serious illness or operation? …….. Yes No
If so, what was the illness or operation? When was it?

_____
_____
_____

Have you ever been hospitalized?…… Yes No
If so, what for?

_____

Do you have, or have you had any of the following diseases or problems?

Damaged heart valves, artificial heart valves or heart murmur …… Yes No
If so, what antibiotic do you use prior to dental appointments? _____
Congenital heart lesions …… Yes No
Rheumatic fever …… Yes No
If so, what antibiotic do you used prior to dental appointments? _____
Cardiovascular disease- circle all that apply – (heart trouble, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ……Yes No
Do you have chest pain upon exertion?…….. Yes No
Are you ever short of breath after mild exercise? ……Yes No
Do your ankles swell? …… Yes No
Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ……Yes No
Do you ever have rapid heartbeat or palpitations? …….. Yes No
Do you have a cardiac pacemaker? …… Yes No
Diabetes …… Yes No
Do you urinate (pass water) more than six times a day? …….. Yes No
Are you thirsty much of the time? …… Yes No
Does your mouth frequently become dry?……Yes No
Hepatitis, jaundice or liver disease …… Yes No
Arthritis …… Yes No
Inflammatory rheumatism (painful, swollen joints) …… Yes No
Stomach Ulcers …….. Yes No
Kidney trouble …… Yes No
Tuberculosis …… Yes No
Do you have a persistent cough or cough up in bed?…… Yes No
Do you experience night sweats? …….. Yes No
Low blood pressure? …….. Yes No
Venereal disease? …… Yes No
Epilepsy? …… Yes No
Psychiatric problems …….. Yes No
Nervous disorders …… Yes No
Cancer ……Yes No
AIDS or other immunosuppressive disorders …… Yes No
Other ……Yes No
……

Have you had any abnormal bleeding associated with previous extractions, surgery or trauma? …… Yes No
Do you bruise easily? …….. Yes No
Have you ever required a blood transfusion? ……Yes No
If so, explain circumstances_____

Arlene R. Kubit, D.M.D.

Member of the American College of Prosthodontists

Do you have any blood disorder such as anemia? …… Yes No
Have you ever been refused as a blood donor? …… Yes No
Do you heal slowly? …….. Yes No
Have you had surgery, radiation or drug treatment for a tumor,
growth, or other condition of your head or neck? …… Yes No
Do you have or have you ever had:
Allergy (common allergies: dust, grass, pollen, animals, food, etc.) ……. Yes No
Sinus trouble …… Yes No
Asthma or hay fever …….. Yes No
Hives or a skin rash ……Yes No
Fainting spells or seizures …… Yes No
Are you allergic or have you reacted adversely to:
Local anesthetics ……Yes No
Penicillin or other antibiotics ……Yes No
Sulfa drugs ……Yes No
Barbiturates, sedatives, or sleeping pills ……Yes No
Aspirin …… Yes No
Iodine …… Yes No
Codeine or other narcotics …… Yes No
Other _____
Have you had any serious trouble associated with previous dental treatment? …Yes No
If so, explain _____
_____
The name and address of my previous dentist is
_____
. _____
_____
List any dental specialists that have treated you. (Such as Periodontist, Endodontist, oral surgeon, orthodontist, Prosthodontist, etc.)
_____
_____

_____
Do you have any disease, condition, or problem not listed above that you think I should know about? If so, please explain.
_____
Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation? ……... Yes No
Are you wearing removable dental appliances? ……. Yes No
List any head/neck trauma (i.e.- car accident, sport injury, falls, blows, beatings, etc.)

_____
Do you suffer from:
Dizziness …….. Yes No
Headaches …… Yes No
Sounds in the ears …… Yes No
Neck pain/stiffness …… Yes No
Pain/numbness/tingling in the arms, legs or face ……Yes No
Any type of paralysis …… Yes No

Arlene R. Kubit, D.M.D.

Member of the American College of Prosthodontists

Your chief dental complaint:

_____

_____

Social habits:

How often do you use:	Never	Occasional	Frequent	Daily
Vitamins	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Aspirin, pain relievers, etc.	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Tranquilizers, sedatives	_____	_____	_____	_____
Cigarettes	_____	_____	_____	_____
Chew tobacco/snuff	_____	_____	_____	_____
Appetite suppressants	_____	_____	_____	_____

Women:

Are you pregnant? ……. Yes No

Are you nursing? …….. Yes No

Do you have any problems associated with your menstrual period? ……. Yes No

Date of last period _____

History of pregnancies:

Number of live born children _____

Number of stillborn children _____

Number of miscarriages _____

Number of Cesarean sections _____

Number of D&Cs _____

List any symptoms of menopause

_____

_____

APPOINTMENTS:

A minimum charge may be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead, which still has to be paid whether you are present, or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE:

To avoid misunderstandings regarding dental/medical insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and our patients are personally responsible for payment of fees. We will help you prepare the necessary forms to help you obtain your benefits form insurance companies. We do not render services on the basis that insurance companies will pay our fees. Each fee is individual for the individual patient.

CONSENT:

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____

Date _____