



Murad Gharibian, D.D.S. Inc.
DG Dental of Newport Beach

Patient's Name _____

Physician Name & No. _____

PATIENT MEDICAL HISTORY

1.	Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	7.	Are you allergic to or have you had any reactions to the following?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Have you ever been hospitalized for any surgical operation or serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	YES	NO	YES	NO	Local anesthetics (eg. Novocaine)	Barbiturates	
3.	Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other Antibiotics	Sedatives	
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	Iodine	
4.	Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	Other _____	
5.	Do you use alcohol, cocaine or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>	8.	WOMEN ONLY:				YES NO	
6.	Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	a)	Are you pregnant or think you may be Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
				b)	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
				c)	Are you on any kind of birth control? _____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you have or have you had any of the following?									
YES	NO	YES	NO	YES	NO	YES	NO			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

PATIENT DENTAL HISTORY

1.	Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8.	Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9.	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10.	Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11.	Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12.	Have you had any orthodontic work?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13.	Have you ever had prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever experienced any of the following problems in your jaw?	<input type="checkbox"/>	<input type="checkbox"/>	14.	Have you ever had instructions on the correct method of brushing your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
	a) Clicking?	<input type="checkbox"/>	<input type="checkbox"/>	15.	Have you ever had instructions on the care of your gums?	<input type="checkbox"/>	<input type="checkbox"/>
	b) Pain (joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>				
	c) Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>				
	d) Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>				

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

X _____

DATE _____