



RICHARD HABER DDS Inc
Medical/Dental History



- 1) Do you presently have or have you had pain or discomfort in the mouth, face, or jaws?
2) Do your gums bleed at any time?
3) Do you have aching or sensitive teeth?
4) Have you had food collection between your teeth?
5) Have you had serious trouble associated with any previous dental treatment?
6) Did you have gum/periodontal treatment before?
7) Date of your last dental treatment :

8) My main reason for coming in today is:

9) Have you been a patient in a hospital during the past two years?
If yes, for what reason?

10) Have you been under the care of a medical doctor during the past two years?
If yes, for what reason?

Please provide the name, address, and telephone number of your physician:

11) Did you whiten your teeth before ?

12) Are you interested in having a cosmetic evaluation.
If yes, please specify what you would like to improve :

13) Are you interested in whiter teeth?

14) Are you currently taking, or have you taken within the past two years, any prescription or non-prescription drugs? If so, please list here:

Table with 3 columns: DRUG, DOSE/FREQUENCY, REASON FOR TAKING

15) Do you have any allergies (i.e., itching, rash, swelling of hands, eyes, or feet), or are you made sick by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, or medications?

If yes, allergic to what?

16) Have you ever had excessive bleeding requiring special treatment?

17) When you walk upstairs or take a walk, do you ever have to stop because of chest pain?

18) Do your ankles swell during the day?

19) Do you use more than two pillows to sleep?

20) Have you lost or gained more than 10 pounds in the last year?

21) Do you wake up short of breath?

22) Are you on a special diet?

23) Women: Are you pregnant now?

Are you currently using a prescription-type contraceptive?

24) Check any of the following which you have had or have at present:

- Yes O No Heart Failure
Yes O No Heart Disease or Attack
Yes O No Angina Pectoris (chest pain)
Yes O No Tuberculosis (TB)
Yes O No Asthma
Yes O No Rheumatic Fever
Yes O No Congenital Heart Lesions
Yes O No Scarlet Fever
Yes O No Artificial Heart Valve

- Yes O No Kidney Disease
Yes O No Stomach Problems
Yes O No Cancer
Yes O No Tumor
Yes O No Shortness of Breath
Yes O No Emphysema
Yes O No Hepatitis
Yes O No Liver Disease
Yes O No Yellow Jaundice

- Yes O No Rheumatism
Yes O No Cortisone Medication
Yes O No Glaucoma
Yes O No Pain in Jaw Joints
Yes O No AIDS or HIV antibody
Yes O No Blood Transfusion
Yes O No Drug Addiction
Yes O No Bruise Easily
Yes O No Sexually Transmitted Disease

(CONTINUED ON NEXT PAGE)

Patient's Name:



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- Yes  No  Heart Pacemaker
- Yes  No  High Blood Pressure
- Yes  No  Heart Murmur
- Yes  No  Heart Surgery
- Yes  No  Artificial Joint
- Yes  No  Fast, Irregular Heartbeat
- Yes  No  Stroke
- Yes  No  Irritable Bowel

- Yes  No  Hay Fever
- Yes  No  Allergies or Hives
- Yes  No  Diabetes
- Yes  No  Thyroid Disease
- Yes  No  Radiation Treatment
- Yes  No  Chemotherapy
- Yes  No  Arthritis
- Yes  No  Sinus Trouble

- Yes  No  Cold Sores or Fever Blisters
- Yes  No  Epilepsy or Seizures
- Yes  No  Fainting or Dizzy Spells
- Yes  No  Nervousness
- Yes  No  Psychiatric Treatment
- Yes  No  Sickle Cell Disease
- Yes  No  Hemophilia or Anemia
- Yes  No  Depression

25) Do you have a history of any genetic, congenital, or family-type disorder? .....  YES  NO

26) Do you have any disease, condition, or problem not listed? .....  YES  NO  
If yes, please describe here: \_\_\_\_\_

27) How do you feel about maintaining a healthy mouth? \_\_\_\_\_  
\_\_\_\_\_

28) How do you feel about the appearance of your teeth? \_\_\_\_\_  
\_\_\_\_\_

29) If you could change anything about your smile, what would you change? \_\_\_\_\_  
\_\_\_\_\_

30) If you have a website , please enter it here: \_\_\_\_\_

To the best of my knowledge, all of the preceding health history answers are true and correct.

Driver's License No: \_\_\_\_\_ State: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(PATIENT OR GUARDIAN)

Person to contact in case of an Emergency: \_\_\_\_\_

Relationship To Patient: \_\_\_\_\_

Phone: \_\_\_\_\_

**MEDICAL HISTORY UPDATE**

Date \_\_\_\_\_ Initials \_\_\_\_\_    Date \_\_\_\_\_ Initials \_\_\_\_\_    Date \_\_\_\_\_ Initials \_\_\_\_\_

Patient's Name: \_\_\_\_\_