Patient's Name: ______________________ Date of Birth: ______________

Welcome to The Vassos Clinic. Your cooperation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain in this office.

	YES	NO
Are you in good heath?	☐	☐
Have there been any changes in your general health within the past year?	☐	☐
Date of your last physical exam ______________		
Physician's Name ______________		
Address ______________		
Phone No. ______________		
Are you now under the care of a physician?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Please explain ______________		
Are you taking any medicine(s) including non-perscription medicine?	☐	☐
If yes, what medicine(s) are you taking? ______________		

	YES	NO
Have you had an abnormal bleeding?	☐	☐
Do you use vitamin supplements?	☐	☐
Have you ever required a blood transfusion?	☐	☐
Have you had recent weight loss?	☐	☐
Have you ever taken Fen-Phen or Redux?	☐	☐
Do you use tobacco?	☐	☐
Do you or have you used controlled substances?	☐	☐
Are you wearing contact lenses?	☐	☐
Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐

WOMEN ONLY

	YES	NO
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	YES	NO
Local anesthetics like novocaine	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Aspirin	☐	☐

	YES	NO
Iodine	☐	☐
Latex / Rubber	☐	☐
Other (Please List) ______________		

DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING:

	YES	NO
Rheumatic heart disease or rheumatic fever	☐	☐
Scarlet fever	☐	☐
Heart defect or heart murmer	☐	☐
Heart trouble, heart attack, or angina	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐

	YES	NO
Tuberculosis	☐	☐
Persistent cough	☐	☐
Cough that produces blood	☐	☐
Chemotherapy (Cancer, Leukemia)	☐	☐
Sexually transmitted disease	☐	☐
Epilepsy or seizures	☐	☐

OVER →

DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING:	YES	NO		YES	NO
Pacemaker	☐	☐	Anemia	☐	☐
Heart surgery	☐	☐	Glaucoma	☐	☐
High/Low blood pressure	☐	☐	Nervousness	☐	☐
Congenital heart problem	☐	☐	Tonsillitis	☐	☐
Swelling of feet, ankles, hands	☐	☐	Tumors	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	Mental health care	☐	☐
Stroke	☐	☐	Back problems	☐	☐
Sinus Trouble	☐	☐	Chemical dependency	☐	☐
Local anesthetics like novocaine	☐	☐	Mitral valve prolapse	☐	☐
Penicillin or other antibiotics	☐	☐	Cortisone treatment	☐	☐
Joint replacement or implant	☐	☐	Cold sores / fever blisters	☐	☐
Stomach ulcer	☐	☐	Hypoglycemia	☐	☐
Kidney trouble	☐	☐	Eating disorders	☐	☐

PATIENT DENTAL HISTORY:	YES	NO		YES	NO
Do your gums bleed while brushing or flossing?	☐	☐	Are you tense during dental visits?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	Are you interested in a method to calm your nerves?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐	Do you chew easily and thoroughly?	☐	☐
Do you feel pain to any of your teeth?	☐	☐	Do you favor one side when chewing?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐	Do you have stomach problems?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐	Have you ever had periodontal treatment (gums)?	☐	☐
Have you ever experienced any of the following problems in your jaw?			Have you ever had a root canal treatment?	☐	☐
Clicking	☐	☐	Have you ever had any difficult extractions in the past?	☐	☐
Pain (Joint, ear, side of face)	☐	☐	Have you ever had any prolonged bleeding following extractions?	☐	☐
Difficulty opening or closing	☐	☐	Do you wear dentures or partials?	☐	☐
Do you have frequent headaches?	☐	☐	If yes, date of placement	☐	☐
Do you clench or grind your teeth?	☐	☐	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

What is the reason for this visit? ______________________________

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Authorization

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.

X ____________________
Signature of patient

Date ____________________

Patient Number:

MEDICAL / DENTAL HISTORY