

# cabrillo dental

FAMILY AND COSMETIC DENTISTRY

Everything you need for a healthy smile

## PATIENT INFORMATION FORM - SECTION 2

PLEASE FILL OUT THIS FORM COMPLETELY

### 5 Medical History

Your current physical condition  Good  Fair  Poor

Are you taking any prescription/over-the-counter  
or herbal supplement drugs?  Yes  No

Please list each one \_\_\_\_\_

Have you ever taken Bisphosphonates?  Yes  No

(Known as Fosamax, Actonel, etc.) if yes, when? \_\_\_\_\_

#### FOR WOMEN ONLY

Are you taking birth control pills?  Yes  No

Are you pregnant?  Yes  No

Are you nursing?  Yes  No

#### HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

- Y  Abnormal Bleeding
- Y  Alcohol/Drug Abuse
- Y  Anemia
- Y  Arthritis
- Y  Artificial Bones, Joints or Valves
- Y  Asthma
- Y  Blood Transfusion
- Y  Cancer/Chemotherapy
- Y  Colitis
- Y  Congenital Heart Defect
- Y  Diabetes
- Y  Difficulty Breathing
- Y  Emphysema
- Y  Epilepsy
- Y  Fainting Spells
- Y  Frequent Headaches
- Y  Glaucoma
- Y  Heart Attack
- Y  Heart Surgery
- Y  Hemophilia

- Y  Hepatitis
- Y  Herpes/Fever Blisters
- Y  High Blood Pressure
- Y  HIV+/AIDS
- Y  Kidney Problems
- Y  Liver Disease
- Y  Lupus
- Y  Osteoporosis
- Y  Pacemaker
- Y  Psychiatric Care
- Y  Radiation Treatment
- Y  Seizures
- Y  Sickle Cell Disease
- Y  Sinus Problems
- Y  Stroke
- Y  Thyroid Problems
- Y  Tuberculosis (TB)
- Y  Ulcers
- Y  Venereal Disease

Please list any medical condition not mentioned above:

Have you ever been hospitalized for any reason? List why:

\_\_\_\_\_  
\_\_\_\_\_

#### ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- Y  Aspirin
- Y  Codeine
- Y  Dental Anesthetics
- Y  Erythromycin
- Y  Jewelry/Metals
- Y  Latex
- Y  Penicillin
- Y  Terracycline

Please list any allergies not mentioned above:

### 6 Medical Information

Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Physician's Name \_\_\_\_\_

Phone # \_\_\_\_\_ Last Visit \_\_\_\_\_

#### IN THE CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name \_\_\_\_\_ Relation \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

### 7 Dental History

Why have you come to the dentist today? \_\_\_\_\_

Has your doctor told you that you require antibiotics  
before dental treatment? Yes  No

Are you currently in pain? Yes  No

Have you ever had a serious/difficult problem associated  
with any previous dental work? Yes  No

Do you or have you ever experienced pain/discomfort  
in your jaw joint (TMJ/TMD)? Yes  No

Your Current dental health is? Good  Fair  Poor

Do you like your smile? Yes  No

Do your gums ever bleed? Yes  No

How many times a week do you use floss?

How many times a day do you brush?

Type of toothbrush bristles?  Hard  Medium  Soft