Dhakar Family Dentistry

Surya P. Dhakar, DDS, PC
MEDICAL/DENTAL HISTORY

Patient's Name: _____ Date of Birth (DOB): _____

Please answer all questions accurately. If you do not understand any questions, please ask us.

*Please **Check** if you have: **(Please Explain Below if any Checked)***

- ☐ AIDS / HIV
- ☐ Allergies (Seasonal)
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Thinners
- ☐ Bone Disorders
- ☐ Cancer / Tumors
- ☐ Chemotherapy / Radiation
- ☐ CHF / Emphysema
- ☐ Heart Murmur / Defects
- ☐ Diabetes
- ☐ Fainting Spells or Seizures
- ☐ Heart Attack / Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice / Liver Disease
- ☐ Joint Replacement
- ☐ Kidney Disease/Trouble
- ☐ Lupus
- ☐ Mental / Nervous Disorder
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Stomach / Gastric Problems
- ☐ Stroke
- ☐ Surgery
- ☐ Tuberculosis
- ☐ Hospitalization for Any Illness
- ☐ Drug or Substance Rehabilitation Program
- ☐ Premedication for Dental Treatment
- ☐ Any Disease / Conditions Not Listed
- ☐ **None of these Conditions Apply**

Explain:_____

_____

Physicians Name & Phone #: _____ Date of Last Dental Exam:_____

List all the medicines/drugs you are currently taking or you may give us a List (write 'None', if none):

_____

_____

Please Check if you are allergic to or have reacted adversely to:

- ☐ local anesthetics
- ☐ penicillin/amoxicillin
- ☐ codeine or other narcotics
- ☐ metals
- ☐ latex
- ☐ other_____

Do you Smoke? (*circle*) Yes / No *If yes:* _____ pack(s) a day

Female Patient Only: Are you pregnant or have recently given birth? (*circle*) Yes / No

If yes, Due Date: _____

What is the reason for your Dental visit? ☐Cleaning/Exam ☐Filling ☐Toothache ☐Other:_____

I have read and answered the above questions completely and accurately to the best of my knowledge.

Patient/Guardian Signature: _____ Today's Date: _____