RAMOUNA KARVAR, D.M.D.

COSMETIC, IMPLANT AND FAMILY DENTISTRY
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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name: _____ Birthday: _____

Please CIRCLE "Yes" or "No" if you have any ANY of the following:

Bad breath	Yes / No	Difficulty chewing	Yes / No	Do you wear a partial denture?	Yes / No
Bleeding gums	Yes / No	Difficulty swallowing	Yes / No	Do you wear a complete denture?	Yes / No
Bad taste	Yes / No	Sensitivity to hot/cold	Yes / No	Are you on a special diet?	Yes / No
Loose teeth	Yes / No	Sensitivity to sweets	Yes / No	Are you concerned with treatment?	Yes / No
Grinding teeth	Yes / No	Sensitivity when biting	Yes / No	Have you lost/gained 10 lbs in past year?	Yes / No
Food packs between teeth	Yes / No	Decayed teeth	Yes / No	How often do you brush? _____	
Pain in jaw/face	Yes / No	Do you use toothpicks?	Yes / No	How often do you floss? _____	
Clicking/popping jaw	Yes / No	Have you worn braces?	Yes / No	Is your toothbrush: soft, medium, hard? _____	

Please CIRCLE "Yes" or "No" if you have experienced ANY of the following:

Abnormal/excess bleeding	Yes / No	Fainting/dizziness	Yes / No	Respiratory disease	Yes / No
AIDS/HIV	Yes / No	Glaucoma	Yes / No	Rheumatic fever	Yes / No
Anemia	Yes / No	Headaches/migraines	Yes / No	Scarlet fever	Yes / No
Arthritis/Rheumatism	Yes / No	Heart murmur	Yes / No	Shingles	Yes / No
Artificial heart valve	Yes / No	Heart problems	Yes / No	Shortness of breath	Yes / No
Artificial joints	Yes / No	Hemophilia	Yes / No	Sinus trouble	Yes / No
Artificial screws/pins	Yes / No	Hepatitis _____	Yes / No	Stomach problems	Yes / No
Asthma	Yes / No	Herpes	Yes / No	Stroke	Yes / No
Back problems	Yes / No	High blood pressure	Yes / No	Swollen ankles/feet	Yes / No
Blood disease	Yes / No	Jaundice	Yes / No	Swollen neck glands	Yes / No
Cancer	Yes / No	Jaw pain	Yes / No	Thyroid problems	Yes / No
Chemotherapy	Yes / No	Kidney disease	Yes / No	Tobacco habits	Yes / No
Circulatory problems	Yes / No	Liver disease	Yes / No	Tonsillitis	Yes / No
Congenital heart lesions	Yes / No	Low blood pressure	Yes / No	Tuberculosis	Yes / No
Cortisone treatment	Yes / No	Mitral valve prolapse	Yes / No	Tumors/growths	Yes / No
Cough (bloody)	Yes / No	Nervous problems	Yes / No	Ulcers	Yes / No
Diabetes	Yes / No	Pacemaker	Yes / No	Venereal disease	Yes / No
Emphysema	Yes / No	Psychiatric care	Yes / No	Other_____	
Epilepsy/seizures	Yes / No	Radiation treatment	Yes / No		

Are you ALLERGIC?
Please CIRCLE "Yes" or "No"

Aspirin	Yes/No
Codeine	Yes/No
Ibuprofen	Yes/No
Latex	Yes/No
Local anesthetics	Yes/No
Metals (i.e. gold)	Yes/No
Penicillin	Yes/No
Sulfa	Yes/No
Acrylic	Yes/No
Other _____	

Have you taken these MEDICATIONS?
Please CIRCLE "Yes" or "No"

Levoxyl	Yes/No
Synthroid	Yes/No
Blood thinners	
Coumadin	Yes/No
Warafin	Yes/No
Diet medications	
Dexfenfluramine	Yes/No
Fen-Phen	Yes/No
Pondimin	Yes/No
Redux	Yes/No

List of Medications

_____
_____
_____
_____
_____
_____
_____

WOMEN: Are you pregnant or think you may be pregnant? Yes / No - DUE DATE: _____ Nursing? NO YES

I have reviewed this questionnaire and answered its questions to the best of my knowledge.

Signature: _____ Date: _____

********** FOR OFFICE USE ONLY **********

DATE: _____ **Blood Pressure: _____Pulse: _____**

Reviewed by Dr. Karvar and/or Hygienist (sign & date) _____