Joseph S. Tutor, DDS

MEDICAL HISTORY

Patient Name: _____ Date of birth:_____
Are you under a physician's care now? Yes____No____ If yes, Doctor's name: _____
Have you ever been hospitalized or had a major operation? Yes_____ No_____
Have you ever had a serious head or neck injury? Yes_____ No_____
Are you taking any medications, pills or drugs? Please list Yes_____ No_____ _____
Do you have photosensitivity? Yes____ No_____
Are you on a special diet? Yes_____No_____
Do you use tobacco? Please specify_____ Yes_____ No_____
Do you use controlled substances? Yes____ No_____
Do you drink fluoridated water? Yes____ No_____
Women: Are you ____ Pregnant/Trying to get pregnant? ___ Nursing? _____Taking oral contraceptives?
Are you allergic to any of the following?
_ Aspirin _Penicillin _Codeine _Acrylic _Metal _Latex _Local Anesthetics _Sulfa _Food _Other_____

Are you aware of needing any pre-medication or antibiotic prior to dental treatment? Yes ____ No ____
If yes, for what condition? _____
Do you have, or have you had any of the following?

o AIDS/HIV Positive	o Excessive Bleeding	o Low Blood Pressure	o Tumors/Growths
o Alzheimer's	o Excessive Thirst	o Lung Disease	o Ulcers
o Anaphylaxis	o Fainting Spells/Dizziness	o MitralValve Prolapse*	o Venereal Disease
o Anemia	o Frequent Cough	o Osteoperosis	o Yellow Jaundice
o Angina	o Frequent Diarrhea	o Pain in Jaw Joints	
o Arthritis/Gout	o Frequent Headaches	o Parathyroid Disease	
o Artificial HeartValve*	o Genital Herpes	o Prostate Cancer	
o Artificial Joint	o Glaucoma	o Psychiatric Care	
o Asthma	o Hay Fever	o Radiation Treatments	
o Blood Disease	o Heart Attack/Failure	o Recent Weight Loss	
o Blood Transfusion	o Heart Murmur*	o Renal Dialysis	
o Breathing Problems	o Heart Pace Maker*	o Rheumatic Fever*	
o Bruise Easily	o Heart Trouble/Disease	o Rheumatism	
o Cancer	o Hemophilia	o Scarlet Fever	
o Chemotherapy	o Hepatitis A	o Shingles	
o Chest Pains	o Hepatitis B or C	o Sickle Cell Disease	
o Cold Sores/Fever Blisters	o Herpes	o Sinus Trouble	
o Congenital Heart Disorders	o High Blood Pressure	o Sleep Apnea	
o Convulsions	o High Cholesterol	o Spina Bifida	
o Cortisone Medicine	o Hives or Rash	o Stomach/Intestinal Disease	
o Diabetes	o Hypoglycemia	o Stroke	
o Drug Addiction	o Irregular Heartbeart	o Swelling of Limbs	
o Easily Winded	o Kidney Problems	o Thyroid Disease	
o Emphysema	o Leukemia	o Tonsillitis	
o Epilepsy or Seizures	o Liver Disease	o Tuberculosis	

Have you ever had any serious illness not listed above? ___ Yes ___ No
If yes please specify _____
Comments:
_____
_____

Patient _____Additional Information (page 2 of Medical History)

Why did you leave your last dentist? _____
When was your last cleaning? _____
What is your present dental problem?
_____

Are your teeth sensitive to:	YES	NO	
Heat, Cold Sweets, Biting Pressure?	O	O	_____
Does food catch between your teeth?	O	O	_____
Do your gums bleed when brushing ?	O	O	_____
Have you noticed any gum swelling around your teeth?	O	O	_____
Do you ever avoid any part of your mouth while brushing?	O	O	_____
Are you dissatisfied with your teeth and their appearance or color?	O	O	_____
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	O	O	_____
Are you deeply concerned about the finances required to return your mouth to excellent dental health?	O	O	_____
Do you grind or clench your teeth?	O	O	_____
Do you play any sports that require a mouth guard?	O	O	_____
Do you have an unpleasant taste or odor in your mouth?	O	O	_____
Have you ever had any teeth removed?	O	O	_____
How long have these teeth been missing?	O	O	_____
Do you feel you will eventually wear artificial dentures?	O	O	_____

Do you have any denture? O Partials O Crowns O Implants How old are they? _____

Do you snore? O O _____