GREENBELT
DENTAL HEALTH
DR. CHRISTOPHER NARANJO

# New Patient Medical / Dental History

## Medical History

(This information will be held in strict confidence)

**Date** *

Month Day Year

**Name** *

First Name Last Name

**Preferred Name**

**Gender** *

**Marital Status**

**Spouse's Name**

**Address** *

Street Address

City

State / Province

Postal / Zip Code

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**Home Phone Number**

Please enter a valid phone number.

**Work Phone Number**

Please enter a valid phone number.

**Cell Phone Number** *

Please enter a valid phone number.

**Email** *

example@example.com

## Emergency Contact

**Emergency Contact Name** *

**Emergency Contact Phone Number** *

Please enter a valid phone number.

**Referred By**

# Dental Questionnaire

**Date of most recent dental visit**

Month Day Year

**Does dental treatment make you nervous?** *

No
Somewhat
Extremely

**My mouth is** *

Very comfortable
Moderately Comfortable
Uncomfortable

**I think the appearance of my mouth is** *

Excellent
Satisfactory
Unsatisfactory

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**Do you use the following?** *

Toothbrush
Dental Floss
Oral Irrigator
Other

**If "Other" Please Explain** *

**How often do you brush?**

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**Do you use a soft toothbrush?** *

Yes No

**Have you ever been treated for periodontal disease (gum disease)?** *

Yes No

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## Do you have, or have you ever experienced the following?

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**Bleeding, Sore Gums** *

Yes No

**Unpleasant Taste / Bad Breath** *

Yes No

**Burning Tongue / Lips** *

Yes No

**Frequent Mouth Blisters** *

Yes No

**Swelling / Lumps in Mouth** *

Yes No

**Orthodontic Treatment (Braces)** *

Yes No

**Biting Cheeks / Lips** *

Yes No

**Clicking / Popping Jaw** *

Yes No

**Loose Teeth** *

Yes No

**Sensitive to Hot** *

Yes No

**Sensitive to Cold** *

Yes No

**Biting Sensitivity** *

Yes No

**Food Impaction** *

Yes No

**Shifting in Bite** *

Yes No

**Clenching / Grinding** *

Yes No

**When?** *

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**Are you having any discomfort at this time?** *

Yes No

**If "Yes" Please Explain** *

**These are the things that are important to me regarding my dental health** *

Yes No

# Health Questionnaire

**Are you in good health?** *

Yes No

**If Not, Explain Briefly** *

**Are you under a physician's care now?** *

Yes No

**If "Yes" Please Explain** *

**Name of health care practitioner**

**Date of last Physical**

Month Day Year

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**Have you had any serious illness or operations?** *

Yes No

**If "Yes" Please Explain** *

**Are you taking any medications? Including OTC supplements** *

Yes No

**If yes, Please List** *

## Are you allergic OR have you reacted adversely to

Aspirin
Penicillin or other antibiotics
Codeine or other analgesic
Sulfa drugs
Lodine
Allergies to other meds
Latex
Local Anesthetics

**If "Allergies to other meds" Please Explain** *

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## Do you have, or have you had, any of the following?

**Anemia** *

Yes No

**Arthritis** *

Yes No

**Asthma** *

Yes No

**Blood Transfusion** *

Yes No

**Breathing Problems** *

Yes No

**Bruise Easily** *

Yes No

**Cancer** *

Yes No

**Type** *

**Chemotherapy** *
Yes No

**Chronic Fatigue Syndrome** *
Yes No

**Cold Sores / Fever Blisters** *
Yes No

**Diabetes** *
Yes No

**Do you take Insulin?** *
Yes No

**Drug Addiction** *
Yes No

**Emphysema** *
Yes No

**Environmental Sensitivities** *
Yes No

**Epilepsy or Seizures** *
Yes No

**Epstein Barr Virus** *
Yes No

**Excessive Bleeding** *
Yes No

**Fibromyalgia** *
Yes No

**Frequent Headaches** *
Yes No

**Hearing / Vision Loss** *
Yes No

**Hemophilia** *
Yes No

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**Hepatitis** *
Yes No

**Type** *
A B
C

**Herpes** *
Yes No

**High Cholesterol** *
Yes No

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**Hives / Skin Rash** *
Yes No

**Joint Pain / Inflammatory Rheumatism** *
Yes No

**Joint Replacement** *
Yes No

**If "Yes" Please Explain** *

**Kidney Problems** *
Yes No

**Lung Disease** *
Yes No

**Multiple Chemical Sensitivity** *
Yes No

**Psychiatric Care** *
Yes No

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**Radiation** *
Yes No

**Sexually Transmitted Disease** *
Yes No

**Stroke** *
Yes No

**Thyroid Disease** *
Yes No

**Tobacco** *
Yes No

**Type** *

**How Often?** *

**Tuberculosis** *
Yes No

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**Ulcers** *
Yes No

**Vertigo** *
Yes No

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## HEART

**Congenital Heart Lesions**
Yes No

**Rheumatic Fever**
Yes No

**High Blood Pressure**
Yes No

**Low Blood Pressure**
Yes No

**Irregular Heart Beat**
Yes No

**Cardiovascular Disease**
Yes No

**Heart Murmur**
Yes No

**Mitral Valve Prolapse**
Yes No

**Do you have a pacemaker?**
Yes No

**Are you on blood thinners?**
Yes No

## WOMEN

**Pregnant**

Yes No

**Nursing**

Yes No

**Taking oral contraceptive**

Yes No

**Signature**

**Name of Patient, Parent or Guardian**

First Name Last Name Month Day Year