

# Health & Dental History

JOSHUA B. BERNSTEIN



Name:  \_\_\_\_\_

Have you been under the care of a medical doctor during the past two years?  Yes  No

If so, for what?  \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Are you taking any medication now, including regular dosages of aspirin?  Yes  No

If so, please list name and dosage  \_\_\_\_\_

Are you aware of having an allergic reaction to any medication or substance?  Yes  No

If so please list  \_\_\_\_\_

Indicate which of the following you have had, or have at present. Check "yes" or "no" to each item.

- |  |                              |  |  |                              |                             |
|--|------------------------------|--|--|------------------------------|-----------------------------|
| Heart Concern <input type="checkbox"/>             | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Congested Ears <input type="checkbox"/>                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congenital Heart Disease <input type="checkbox"/>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Dizziness <input type="checkbox"/>                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Murmur <input type="checkbox"/>              | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Ringling Ears <input type="checkbox"/>                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure <input type="checkbox"/>       | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Loose Teeth <input type="checkbox"/>                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mitral Valve Prolapse <input type="checkbox"/>     | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Posture Problems <input type="checkbox"/>                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Heart Valve <input type="checkbox"/>    | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Clenching <input type="checkbox"/>                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker <input type="checkbox"/>                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Grinding <input type="checkbox"/>                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke <input type="checkbox"/>                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Facial Pain <input type="checkbox"/>                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma <input type="checkbox"/>                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Sensitive Teeth <input type="checkbox"/>                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver Disease/Jaundice <input type="checkbox"/>    | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Neck Pain <input type="checkbox"/>                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Latex Sensitivity <input type="checkbox"/>         | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Bell's Palsy <input type="checkbox"/>                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Joints <input type="checkbox"/>         | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Difficulty Swallowing <input type="checkbox"/>             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Trouble <input type="checkbox"/>            | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Difficulty Chewing <input type="checkbox"/>                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Radiation/Chemotherapy <input type="checkbox"/>    | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Trigeminal Neuralgia <input type="checkbox"/>              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy/Seizures <input type="checkbox"/>         | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Tingling in Arms/Fingers <input type="checkbox"/>          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/>                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Insomnia/Frequent Waking <input type="checkbox"/>          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis <input type="checkbox"/>                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Have you had braces? <input type="checkbox"/>              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| AIDS/HIV <input type="checkbox"/>                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Do you see a chiropractor? <input type="checkbox"/>        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sickle Cell Disease <input type="checkbox"/>       | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Does floss shred with you use it? <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neurological Disorders <input type="checkbox"/>    | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Does food pack or catch between <input type="checkbox"/>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychiatric/Psychological <input type="checkbox"/> | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | your teeth? <input type="checkbox"/>                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headaches <input type="checkbox"/>                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Do you smoke or chew tobacco? <input type="checkbox"/>     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Jaw Pain <input type="checkbox"/>                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Do your gums bleed? <input type="checkbox"/>               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Jaw Popping <input type="checkbox"/>               | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> | Does your breath concern you? <input type="checkbox"/>     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Limited Opening <input type="checkbox"/>           | <input type="checkbox"/> Yes | <input type="checkbox"/> No                          |  |                              |                             |

Do you have or have you had any disease, condition or problem not listed?  Yes  No If yes, please describe  \_\_\_\_\_

Emergency contact: Name \_\_\_\_\_ Relation:  \_\_\_\_\_

Phone #1 (\_\_\_\_) \_\_\_\_\_ Phone #2 (\_\_\_\_) \_\_\_\_\_

Women—Are you: Pregnant  Yes  No Nursing  Yes  No Taking birth control pills  Yes  No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email address \_\_\_\_\_

For more information, please visit our website at [www.allnewsmiles.com](http://www.allnewsmiles.com).

**Remember to fax these back to our office at 510-601-7646 two days prior to your visit, or mail them to our address in the enclosed envelope.**

## COSMETIC DENTISTRY

1375 GRAND AVENUE  
S U I T E 2 0 1  
PIEDMONT, CA 94610  
PHONE 510.601.SMILE  
PHONE 510.601.7645  
FAX 510.601.7646  
[www.allnewsmiles.com](http://www.allnewsmiles.com)