Ridge Dental - Office of Dr. Nisrine Cabani DMD

Medical Dental History Form

Patient Name: _____ Physician: _____

Current Medications (Prescription, over the counter and herbal):

Medication	Reason	Medication	Reason

Allergies to:

Latex: Yes No

Other: _____

PreMed required? Yes No

Reason: _____

Past and current medical conditions (mark all that apply):

Under physician's care?		Cancer?	
Hospitalization/operation(s) in the last 5 years?		Radiation Treatment to Head/Neck?	
Head/neck/mouth injuries?		Chemotherapy?	
Women: pregnant?		Kidney Disease?	
Women: nursing?		Dialysis?	
Women: oral contraceptives?		Eating Disorder?	
Heart trouble/disease?		Stomach: Reflux? Ulcer?	
Rheumatic fever?		Immunological disease?	
Past use of Fenphen?		Sjogrens Disease?	
Heart murmur?		Fibromylagia?	
Mitral valve prolapse?		Other autoimmune disease (lupus, pemphigus)?	
Heart surgery?		Arthritis or other joint disorders?	
Artificial heart valves?		Diabetes? Type: Controlled? Y N	
Pacemaker?		Headaches?	
Indwelling defibrillator?		Depression: Diagnoses?	
Artificial joints?		Other Psychiatric Disorders?	
History of Organ Transplant?		Neurologic Disease?	
High blood pressure?		Convulsions?	
Stroke?		Epilepsy/seizures?	
Bleeding problem?		Cerebral Palsy?	
Hemophilia?		Fainting/dizziness?	
Anemia?		Venereal disease?	
Leukemia?		AIDS/HIV positive?	
Lung disease?		Alcohol or chemical dependency?	
Emphysema?		Hepatitis?	
Shortness of Breath?		Thyroid disease?	
Asthma?		Glaucoma?	
Sleep Apnea?		Tobacco user? Current Former Number of years:	
Tuberculosis?		Are you interested in quitting tobacco?	
Sinus trouble?			

Do you have consistent problems with:

Dry mouth/excessive thirst?	
Sensitive teeth? Hot Cold Pressure Sweets	
Mouth odors/bad taste?	
Cold sores/blisters/oral lesions?	
Are you aware of any swelling or lumps?	
Sore, bleeding gums?	
Loose teeth?	
Difficulty chewing?	
Food catches between teeth?	
Teeth/filling break frequently?	
Clenching or grinding habits?	
Do you hear popping or clicking in your jaw?	
Do you have jaw pain?	
Are you nervous about dental work?	

Dental Information:

Previous dentist:
Last dental visit:
Last dental cleaning:
Frequency of dental exams:
What made you decide to make this dentist appointment?
Frequency of brushing:
Frequency of flossing: