Amine G. Khoury, D.D.S.
3434 Villa Lane Suite 160, Napa, California 94558

DENTAL AND MEDICAL HISTORY FOR:

Patient Name_____Date_____

	Yes	No
Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain_____	☐	☐
Are you taking any medication(s) including non-prescription medicine(s)?	☐	☐

If yes, please list the medication(s) you are taking:

Medication	Reason	Quantity

Do you use tobacco?	☐	☐
Do you drink alcohol?	☐	☐
Are you allergic to or have you had any reactions to the following:		
Antibiotics, like Penicillin or Erythromycin	☐	☐
Aspirin	☐	☐
Barbiturates	☐	☐
Iodine	☐	☐
Latex	☐	☐
Local anesthetics, like Novocaine or Benzocaine	☐	☐
Metals, like nickel, mercury, copper, etc.	☐	☐
Sedatives	☐	☐
Sulfa drugs	☐	☐
Other_____	☐	☐
WOMEN only:		
Are you pregnant or think you may be pregnant?	☐	☐
Due Date_____		
Are you breast feeding?	☐	☐
Are you taking oral contraceptives?	☐	☐

Do you have any of the following conditions?

	Yes	No		Yes	No
AIDS/HIV infection	☐	☐	Hepatitis	☐	☐
Anemia	☐	☐	Hypoglycemia	☐	☐
Artificial Heart Valve	☐	☐	Jaundice	☐	☐
Artificial joints or hip	☐	☐	Kidney problems or disease	☐	☐
Arthritis or Rheumatism	☐	☐	Liver problems or disease	☐	☐
Asthma	☐	☐	Mitral Valve Prolapse	☐	☐
Blood pressure, **HIGH**	☐	☐	Neurological disorders	☐	☐
Blood pressure, **LOW**	☐	☐	Nervous or anxious	☐	☐
Bruise easily	☐	☐	Pacemaker	☐	☐
Cancer or tumor(s)	☐	☐	Radiation therapy	☐	☐
Chemotherapy	☐	☐	Rheumatic fever	☐	☐
Diabetes	☐	☐	Seizures	☐	☐
Emphysema	☐	☐	Sinus problems	☐	☐
Epilepsy	☐	☐	Stroke	☐	☐
Fainting or dizziness	☐	☐	Thyroid problems or disease	☐	☐
Glaucoma	☐	☐	Tonsil or adenoid problems	☐	☐
Hay fever or seasonal allergies	☐	☐	Tuberculosis	☐	☐
Heart Murmur	☐	☐	Ulcers	☐	☐
Heart surgery, disease or attack	☐	☐	Other, please list	☐	☐
Hemophilia	☐	☐			

Date of: _____

Last dental visit_____Dental cleaning_____Full mouth radiographs(x-rays)_____

Previous Dentist Name_____ City/State_____

How often do you: Brush your teeth_____Floss_____ Use mouthwash_____
What other dental aids do you use? (Sonicare, toothpick, proxy brush, endtuft brush, etc.)_____
_____

Please answer the following:

Do you have active problems now?

	Yes	No		Yes	No
Bad breath	☐	☐	Food catches between teeth	☐	☐
Bleeding gums	☐	☐	Gum Disease	☐	☐
Broken teeth	☐	☐	Loose teeth	☐	☐
Change in bite	☐	☐	Pain around ear	☐	☐
Clicking or popping jaw	☐	☐	Sores or lumps in or near mouth	☐	☐
Decay	☐	☐	Tooth pain	☐	☐

Have you ever had?

	Yes	No		Yes	No
Orthodontics (braces)	☐	☐	Periodontal treatment	☐	☐
Oral surgery or teeth removed	☐	☐	Endodontic treatment (root canal)	☐	☐
Head, neck or jaw injuries	☐	☐	Teeth ground or bite adjusted	☐	☐
Broken jaw	☐	☐	General anesthesia	☐	☐
Missing back teeth	☐	☐	A bite plate or guard	☐	☐
MRI	☐	☐	CT scans	☐	☐
Eye examination	☐	☐	Wear contact lenses now	☐	☐

If yes, date of last exam_____

Cortisone injected into joints ☐ ☐
If yes, when?_____By whom?_____
How many injections?_____

Prolonged bleeding either from a cut or a dental procedure such as a cleaning ☐ ☐
An accident or injury(includes sports injury, serious slips or falls, ski accidents, etc.) ☐ ☐
If yes, when_____Briefly, what happened_____
_____
_____

Occlusal habits, do you?

	Yes	No		Yes	No
Clench or grind your teeth	☐	☐	Teeth hit in front first	☐	☐
Bite your cheeks regularly	☐	☐	Smoke a pipe	☐	☐
Bite your nails	☐	☐	Chew gum	☐	☐
Bite on a pen or pencil	☐	☐	Have tired jaws, especially in a.m.	☐	☐

Are any of your teeth sensitive to:

	Yes	No		Yes	No
Biting or chewing	☐	☐	Cold	☐	☐
Sweets	☐	☐	Hot	☐	☐

AUTHORIZATION: I hereby authorize Amine G. Khoury, D.D.S. and his staff to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears, on this history is correct to the best of my knowledge. I also authorize the doctor and his staff to contact my healthcare giver(s) concerning treatment if necessary. I authorize Amine G. Khoury and his staff to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers.

Patients Signature:_____ Date:_____