Charles Khoury, D.M.D, Inc.

MEDICAL HISTORY FORM TODAY'S DATE___

Name:_____ **Home Phone: ( )**_____
Last first middle

Home Address:_____ **Zip Code**_____
Number, street city & state

Cell Phone:( )_____ **Date of Birth:___/___/___ Sex: M / F Marital Status: S / M**

Email Address:_____Would you like us to confirm via email or phone (circle one)

Work - Company:_____/_____/_____
Occupation Company Work Phone (for last minute changes to the schedule)

Social Security #:_____ **Name of Spouse or Closest Relative:**_____

If you are completing this form for another person, what is your relationship to that person?_____

How did you learn of this office? (we would like to thank those who sent you)_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health?…….. YES NO
2. Has there been any change in your general health within the past year?……. YES NO
3. My last physical examination was on: _____
4. Are you now under the care of a physician?…….…… YES NO
   If so, what is the condition being treated?_____
5. The name and address of my physician(s) is_____
   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?……..…YES NO
   If so, what was the illness or problem?_____
7. Are you taking any medicine(s) including non-prescription medicine (ie. aspirin)……....YES NO
   If so, what medicine(s) are you taking?_____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease……yes no
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion)……..…yes no
      1. Do take premedication (antibiotics) prior to dental visits?…….…….yes no
      2. Are you ever short of breath after mild exercise or when lying down?……yes no
      3. Do you have high blood pressure?……yes no
      4. Do you have inborn heart defects?……yes no
      5. Do you have a cardiac pacemaker?……yes no
   c. Artificial joints/pins or plates……...yes no
   d. Sinus trouble……yes no
   e. Asthma ……yes no
   f. Allergies/Hayfever……...…….yes no
   g. Fainting spells or seizures……yes no
   h. Bulimia or anorexia……yes no
   i. Diabetes……yes no
   j. Hepatitis (A, B or C?), jaundice or liver disease……...……..yes no
   k. Aids or HIV infection……yes no
   l. Thyroid problems……yes no

m. Respiratory problems……yes no
n. Arthritis or painful swollen joints……yes no
o. Stomach ulcer or hyperacidity……yes no
p. Kidney trouble……yes no
q. Tuberculosis……yes no
r. Persistent cough or cough that produces blood……yes no
s. Persistent swollen glands in the neck region……yes no
t. Low blood pressure……yes no
u. Sexually transmitted disease……yes no
v. Epilepsy or other neurologic disease……yes no
w. Problems with mental health……yes no
x. Cancer……yes no
y. Problems of the immune system……yes no

9. Have you had any abnormal bleeding?……YES NO
10. Have you or do you take Boniva or Fosamax, or their equivalent?..... YES NO
11. Do you have any blood disorder such as anemia or leukemia?……... YES NO
12. Have you ever had any treatment for a tumor or growth?……... YES NO
13. Are you allergic or had a reaction to:
    a. Local anesthesia……yes no
    b. Penicillin……yes no
    c. Sulfa drugs……yes no
    d. Other antibiotics……yes no
       if yes, which ones? _____
    e. Aspirin……yes no
    f. Iodine……yes no
    g. Codiene or other narcotics……yes no
    h. Anything else not listed above_____

14. Have you had any serious trouble associated with prior dental treatment?……YES NO
    If so, please explain_____
15. Do you have any disease, condition, or problem not listed above that you think I should know about? …….. YES NO
    If so, please explain_____
16. Are you wearing contact lenses?…….……YES NO
17. Are you wearing any dental appliances?…….…YES NO

WOMEN ONLY

18. Are you pregnant?…….……YES NO
19. Do you have any problems with your menstrual period?…….…… YES NO
20. Are you nursing?……..……..YES NO
21. Are you taking birth control pills? (antibiotics will diminish their effect)……..……..YES NO

WHAT IS YOUR CHIEF DENTAL CONCERN? (ie. pain, esthetics, function, etc.)_____

HAS ANYTHING PREVENTED YOU FROM ADDRESSING THIS CONCERN IN THE PAST?_____

WHAT CAN WE DO TO BETER SERVE YOU THAN IN YOUR PAST DENTAL EXPERIENCES?_____

WHAT ASPECT OF YOUR SMILE WOULD YOU LIKE TO CORRECT THE MOST_____

WHEN WAS YOUR LAST VISIT TO A DENTAL OFFICE AND WHAT DID YOU HAVE DONE?_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I further authorize this office to verify my credit history/rating if credit terms will be extended for therapy. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions I have made in the completion of this form.

_____ _____

Signature of the Patient or Guardian Doctor's Signature & Date