DATE ___/___/___

All medical/dental history records are strictly confidential and will not be disclosed anywhere without the expressed permission of the patient

PATIENT INFORMATION

Name/surname:_____
Date of birth:_____ Occupation:_____
Address:_____ phone number / mobile:_____
Who recommended our clinic to you?_____

ORAL HELTH QUESTIONS

	YES	NO
Do you feel stressed by the thought of visiting the dentist?		
Have you ever had an abnormal reaction to an anesthetic used by your dentist?		
Have you ever noticed bleeding that lasted for more than two days after a tooth extraction?		
Do you hear any clicking sound by your jaw bones while chewing?		

GENERAL HEALTH QUESTIONS

	YES	NO
Do you faint often?		
Are you taking any medication during this period?		
If so, what?_____		
Do you smoke?		
Are you allergic to any medication or any other factor?		
If so, what?_____		
Are you pregnant?		

PLEASE NOTE IF YOU HAVE ANY OF THESE PROBLEMS

	YES	NO		YES	NO
hemophilia			orthopedic prostheses (blades, titanium screws)		
epilepsies			chronic bronchitis, asthma		
anemia			tuberculosis		
hypertension			stomach ulcer, gastritis		
heart problems			diabetes		
mitral valve prolapse			kidney disorders		
snort			syphilis		
heart surgery			liver disorders		
by pass,artificial valve			hepatitis A, B,or C		
add pacemaker			AIDS, HIV		
cancer			are you taking the contraceptive pill?		
radiotherapy / chemotherapy					

Do you have any other medical problem?_____

Signature