PAUL VARTABEDIAN, DDS
Prosthetic, Cosmetic & Implant Dentistry
YOUR SMILE. OUR PASSION.

MEDICAL INFORMATION

Patient Name: ______________________________

Physician Name: ______________________________ City: ____________________ Phone: _______________
Date of most recent physical exam: _______________ **Pharmacy:** _________________________________

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Acid Reflux Disease	☐ Allergies / Hives	☐ Allergy: Codeine	☐ Allergy: Iodine
☐ Allergy: Latex	☐ Allergy: Penicillin	☐ Allergy: Septra	☐ Allergy: Sulfa
☐ Allergy:Hydrocodone	☐ Allergy:Tetracycline	☐ Angina Pectoris	☐ Anxiety
☐ Arthritis	☐ Artificial Joints	☐ Asthma	☐ Autoimmune Disorder
☐ Blood Disorder	☐ Blood thinners	☐ Blood Transfusion	☐ Cancer- head/neck
☐ Cancer	☐ Chemotherapy	☐ Chronic Cough	☐ Cold Sores
☐ Coumadin Therapy	☐ Diabetes	☐ Dizziness / Fainting	☐ Dry mouth
☐ Emphysema	☐ Epilepsy	☐ Epinephrine Sens	☐ Hay Fever
☐ Heart Disease	☐ Heart Murmur	☐ Heart Valve Surgery	☐ Hepatitis A
☐ Hepatitis B	☐ Hepatitis C	☐ High Blood Pressure	☐ HIV
☐ Kidney Trouble	☐ Liver Disease	☐ Lupus	☐ Mental Disorders
☐ Mitral Valve Prolaps	☐ Neuro Disorder	☐ Osteoperosis meds	☐ Other
☐ Pacemaker	☐ Physical Disability	☐ Pregnancy	☐ Premed - Not Needed
☐ Premed	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Seizure Disorder	☐ Sinus Problems	☐ Stroke	☐ Thyroid Disease
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

☐ Ever been hospitalized (illness or injury)
☐ A smoker or smoked previously
☐ FEMALE: Taking birth control pills
☐ Presently being treated for any other illnesses
☐ History of chewing tobacco
☐ FEMALE: Pregnant

If any conditions/alerts selected above need further clarification or you have conditions not listed above, please describe below:

____

Covid-19 vaccinated: YES NO

Current medications: ____

____

Have you ever taken Bisphosphonates (Fosamax, Reclast, Boniva, Didronel, Actonel, Aclasta, Aredia, Atelvia, Skelid, Zometa)? YES NO If yes, please list medication_____________________________

Do you take antibiotic premedication for your dental visits? YES NO
If yes, what medication and for what reason? ____

Patient/Guardian Signature: ____________________________________ **Date:** ___________

Dentist: **Date reviewed:** ____________ **BP/Pulse:** ____________

Patient Name: ______________________________

Previous Dentist name and reason for leaving: ____

Date of last dental cleaning: _________ Date of last xrays: _________ Brush: ____/day Floss: ____/day

Toothbrush: manual/electric

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)

Personal Dental History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Had periodontal treatment (gum surgery, root planing)
☐ Had any teeth removed
☐ Feel nervous about having dental treatment
☐ Had trouble getting numb
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?
☐ Have you ever whitened (bleached) your teeth?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint
☐ You have problems chewing
☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
☐ Your teeth are crowding or developing spaces
☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
☐ You clench your teeth in the day or night
☐ You have problems with sleep or wake up with an awareness of your teeth, tired jaws
☐ You have clicking or popping of the jaw
☐ Your jaw has locked open or closed
☐ You have pain in the jaw joint, ear, or side of face
☐ You have or had a bite appliance (night guard)

Tooth structure, Check all that apply:

☐ Cavities within past 3 years
☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
☐ You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
☐ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
☐ Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
☐ Food gets caught between any teeth

Gum and Bone, Check all that apply:

☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ History of periodontal disease in your family
☐ Experienced gum recession
☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple
☐ Experienced a burning sensation in your mouth