DAVID K BURAN
DENTISTRY

PATIENT MEDICAL HISTORY

Patient's Medical History

Physician Information

Physician's Full Name: _____

City, State and ZIP: _____

Are you currently under a physician's Care? Yes No

If Yes, for what?

Have you been hospitalized in the last two years? Yes No

If Yes, for what?

Are you taking any medication, drugs or pills? Yes No

If so, please list the names and dosages of each:

Do you Smoke? Yes No How Much? _____

Women Only

Are you pregnant? Yes No Are you taking birth control pills? Yes No

Are you nursing? Yes No Are you on Hormone Therapy? Yes No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Medical Alerts

Allergic to Penicillin	Allergic to Codeine	Pre-Medication required	Pacemaker
Allergic to Tetracycline	Allergic to 'Novocaine'	Mitral Valve Prolaspe	HIV Positive
Allergic to Aspirin	Allergic to Latex Rubber	Heart Problems	Prior Hepatitis

Other

Medical Conditions

Heart Attack	Excessive Bleeding when Cut	Chemotherapy	Osteoporosis
Heart Murmur	Sickle Cell Disease	Ulcers	Swelling of Feet/Ankles
Chest Pain	Glaucoma	Gastrointestinal Upset	Artificial Joint Replacement
Congenital Heart Problem	Diabetes	Acid Reflux	Psychiatric Care
Artificial Heart Valve	Excessive Thirst	Lung Disease	Epilepsy or Seizures
Heart Surgery	Scarlet Fever	Tuberculosis	Extreme Nervousness
High/Low Blood Pressure	Thyroid Disease	Shortness of Breath	Fainting or Dizziness
Rheumatic Fever	Parathyroid Disease	Emphysema	Hypoglycemia
Anemia	Kidney Disease	Asthma	Hives
Blood Disease	Liver Disease	Sinus Trouble	Cold Sores/Fever Blisters
Blood Transfusion	Hepatitis A or B	Hay Fever	Venereal Disease
Stroke	Yellow Jaundice	Frequent Cough	Herpes
Deep Vein Clot	Cancer	Rheumatism	Cortisone Treatment
Hemophilia	X-Ray or Cobalt Treatment	Arthritis/Gout	Chemical Dependency

DAVID K BURAN
DENTISTRY

PATIENT DENTAL HISTORY

Patient's Dental History

What is your primary reason for seeking dental care?

_____

Previous Dentist Information

Dentist's Full Name: _____

City, State and ZIP: _____

Month and Year of Last Visit: _____

What was done at your last visit? _____

Date of Last full mouth x-rays: _____

Reason for leaving previous dentist: _____

How often do you visit the dentist? Annual Check Up Twice a Year Check Up

Only when I have a problem Other

Please choose the appropriate answer

Are you nervous about receiving dental treatment?	Yes	No
Do you gag easily?	Yes	No
Have you had previous problems with dental care?	Yes	No
If so, please explain?		
Are your teeth sensitive to hot, cold, pressure or sweets?	Yes	No
Do you have problems with teeth/fillings breaking?	Yes	No
Are you aware of an uncomfortable bite?	Yes	No
Do your gums feel tender and/or bleed?	Yes	No
Does food catch between your teeth?	Yes	No
Have you had periodontal (gum) treatments?	Yes	No
Do you get sores in or around your mouth?	Yes	No
Do you have regular headaches, earaches or neck pains?	Yes	No
Do you grind or clench your teeth?	Yes	No
Do you hear a "clicking" sound when you open/close your mouth?	Yes	No
Does your jaw ever get "stuck?"	Yes	No
Do you have a Temporomandibular (TMJ) jaw disorder?	Yes	No

Are you missing teeth that have not been replaced?	Yes	No
Have you had excessive bleeding after an extraction?	Yes	No
Have you had mouth sores that take long to heal?	Yes	No
Do you have any dental implants?	Yes	No
Do you wear dentures (partials or full)?	Yes	No
Do you have any crowns (caps) or bridges?	Yes	No
Do you chew tobacco?	Yes	No
Do you have a dry mouth?	Yes	No
Are you unhappy with the appearance of your teeth?	Yes	No
Would you like your smile to look better?	Yes	No
Would you like whiter teeth?	Yes	No
Do you regularly use dental floss?	Yes	No
Do you brush at least once daily?	Yes	No

Is there anything else that you would like us to know?

I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site. Yes No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____