Time 10:45 AM | Anthony Elgohary, DMD. PLLC | Date 10/3/2016

Dr. Elgohary Medical Form

Patient Name: Birth Date: Date Created:

Medical

Are you currently under the care of a physician? ◯ Yes ◯ No If yes

Are you currently taking any medications? ◯ Yes ◯ No If yes

Do you have or have you ever had?

Condition		Condition		Condition		Condition	
Arthritis	◯ Yes ◯ No	Asthma or Breathing Problems	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Pace Maker	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Epilelpsy/Convulsions	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Convulsions/Dizzy Spells	◯ Yes ◯ No	Hepatitis: Type______	◯ Yes ◯ No	Heart Problems/Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Prosthetic Heart Valve	◯ Yes ◯ No	AIDS or HIV infections	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Sexually Transmitted Diseases	◯ Yes ◯ No	Joint Replacement(Including Hip)	◯ Yes ◯ No
Low Blook Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Thyroid Problems	◯ Yes ◯ No
Radiation Therapy	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Bleeding Disorders	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	Circulatory Problems	◯ Yes ◯ No	Tobacco Use: Frequency______	◯ Yes ◯ No	Alcohol Use: Frequency_______	◯ Yes ◯ No

Are you currently pregnant: ◯ Yes ◯ No

Surgeries: ◯ Yes ◯ No If yes

*Are you taking any of the following meds:

Medication		Medication		Medication	
Fosamax	◯ Yes ◯ No	Actonel	◯ Yes ◯ No	Boniva	◯ Yes ◯ No
Aredia	◯ Yes ◯ No	Zometa	◯ Yes ◯ No	Humira	◯ Yes ◯ No

Are you allergic to?

Allergen		Allergen		Allergen	
Local Anesthetic	◯ Yes ◯ No	Latex	◯ Yes ◯ No	Aspirin	◯ Yes ◯ No
Codeine	◯ Yes ◯ No	Barbiturate	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No

Other: ◯ Yes ◯ No If yes

Additional Comments

For Office Use:

Blood Pressure Reading:

Heart Rate Reading:

Dental History

What is the reason for today's visit?

How did you hear about us?

Previous or Referring Dentist Name:

Date of Last X-rays?

What was done at your last dental visit?

How often do you brush?

How often do you floss?

Do you use well water? ◯ Yes ◯ No

Do you wear removable partials/dentures? How old are they? Are you happy with them? ◯ Yes ◯ No

Have you had orthodontic treatment? ◯ Yes ◯ No

Have been told that you have TMJ or grind your teeth? If yes, do you wear a night guard? ◯ Yes ◯ No

Are your teeth or gums uncomfortable or sensitive? ◯ Yes ◯ No

Have you ever had any dental surgery? ◯ Yes ◯ No

Have you ever received treatment for periodontal disease? ◯ Yes ◯ No

Are you anxious to keep your natural teeth? ◯ Yes ◯ No

Would you like whiter teeth? ◯ Yes ◯ No

Do you love your smile?

Check if you have had problems with any of the following:

Problem		Problem		Problem		Problem	
Bleeding gums	◯ Yes ◯ No	Tender/Swollen Gums	◯ Yes ◯ No	Bad Breath	◯ Yes ◯ No	Frequent Canker Sores	◯ Yes ◯ No
Loose Teeth	◯ Yes ◯ No	Loose Fillings	◯ Yes ◯ No	Sensitivity	◯ Yes ◯ No	Clicking/Popping in Jaw	◯ Yes ◯ No
Gagging	◯ Yes ◯ No	Missing Teeth	◯ Yes ◯ No	Crooked Teeth	◯ Yes ◯ No		

Signatures

Signature of Patient, Parent or Guardian:

X Date:___________