Dr. Mojgan Niktash, D.D.S. 31726 Ranch Viejo Road, San Juan Capistrano, CA 92675

DENTAL HISTORY: **Name:** ----------
DOB: ----------

Reason for today's visit: _____

Your current dental health is: Good Fair Poor

Date of last dental Visit: _____

Do you:

Require antibiotics before dental treatment? Y N

Have pain now? Y N

Now have or experienced pain /discomfort in your jaw joint? Y N

Clench or grind your teeth while asleep or awake? Y N

Like your smile? Y N

Have bleeding gums? Y N

Have sensitivity in any of your teeth? Y N

You have family history of gum disease or tooth loss? Y N

Have mouth odors? Y N

Do food tend to be caught between your teeth? Y N

How many times a week do you floss? ____ a day do you brush? _____

Have you ever had?

Orthodontic treatment? Y N

Oral surgery? Y N

Periodontal treatment? Y N

Your teeth ground or the bite adjusted? Y N

A bite plate or mouth guard? Y N

Headaches, neck aches or shoulder aches? Y N

A serious/ difficult problem associated with any Previous dental work? Y N
If so, please describe, including cause: _____

_____

A serious injury to the mouth or head? Y N
If so, please describe, including cause: _____

_____

Have you ever taken Phen-Fen? (also known as Redux or Pondimin) Y N
If so, when? _____

Have you ever taken Fosamax? Y N
If so, when? _____

Is there anything else you would like for Dr. Niktash to know?

_____

MEDICAL HISTORY:

Your current medical health is: Good Fair Poor

Do you smoke or use tobacco in any other form? Y N

Are you currently under a physician's care? Y N

Please explain: _____

Are you taking any prescription/ over-the-counter drugs? Y N

Please list: _____

_____

For Women: Are you taking birth control pills? Y N

Are you pregnant? Y N Week#: _____

Are you nursing? Y N

Have you ever had any of the following disease or medical problems?
(Please circle all options that apply)

Y N Anemia/Radiation Treatment	Y N Hemophilia/Abnormal Bleeding
Y N Artificial Bones/Joints/Valves	Y N Hepatitis
Y N Arthritis	Y N High/Low Blood Pressure
Y N Asthma	Y N HIV+/AIDS
Y N Blood Transfusion	Y N Hospitalized for Any Reason
Y N Cancer/Chemotherapy	Y N Kidney Problems
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Severe/Frequent Headaches
Y N Drug/Alcohol Abuse	Y N Shingles
Y N Emphysema/Glaucoma	Y N Sickle Cell Disease/Traits
Y N Epilepsy/Seizures/Fainting Spells	Y N Sinus Problems
Y N Fever Blisters/Herpes	Y N Tuberculosis (TB)
Y N Heart Attack/Stroke	Y N Ulcers/Colitis
Y N Heart murmur	Y N Venereal Disease
Y N Heart Surgery/Pacemaker	Y N Thyroid

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine

Y N Jewelry/Metals Y N Tetracycline Y N Dental Anesthetics Y N Latex

Please list any other drugs/material that you are allergic to:

_____

Patient/responsible party Signature

OFFICE USE ONLY:
I verbally reviewed the medical/dental information above with the patient named herein.

Dentist Signature----------