Malinoski & Associates, D.D.S., P.C.
717 Health Parkway
Three Rivers, MI 49093
(269)279-7876

NAME ________________________________

ADDRESS ______________________________

PHONE ________________________________

D.O.B. ________________________________

HEALTH & DENTAL HISTORY

1. Are you satisfied with the present condition of your teeth?.. YES NO
2. Are you satisfied with the present condition of your gums?.. YES NO
3. Are you satisfied with the present condition of your smile?.. YES NO
4. Are you having dental pain or discomfort at this time?.. YES NO
   How would you describe this pain?____
5. Has your doctor ever requested you to take an antibiotic before dental treatment?......................... YES NO
   Which antibiotic and reason why?____
6. Have you been a patient in the hospital during the past two years?... YES NO
7. Are you under the care of a physician at the present time?... YES NO
8. Have you been under the care of a medical doctor during the past two years?................................ YES NO
   If yes, for what?____
9. Please provide Physician's name
   Address ______________________________________Phone#____________________
10. Are you now taking an medication, drugs or pills?... YES NO
    If yes, please list:____
11. Are you aware of being allergic to or have you ever reacted adversely to any
    medication or substance?.. YES NO
    If yes, please list:____
12. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Condition			Condition		
Heart Failure………………………	YES	NO	Arthritis…………………………………	YES	NO
Heart Disease or Attack………..….	YES	NO	Back Problems………………………….	YES	NO
Angina Pectoris…………………...	YES	NO	Cortisone Medicine……………………..	YES	NO
Low Blood Pressure…………….….	YES	NO	Glaucoma……………………..………	YES	NO
Heart Murmur ……………….…….	YES	NO	Pain in Jaw Joints……………………...	YES	NO
Rheumatic Fever………………….….	YES	NO	AIDS / HIV………………………..….	YES	NO
Congenital Heart Condition……….	YES	NO	Immuno Suppressive Disorder………….	YES	NO
Scarlet Fever……………………...	YES	NO	Swollen Neck Glands……………..…….	YES	NO
Artificial Heart Valve …………….….	YES	NO	Hepatitis A (infectious)…………...…..	YES	NO
Heart Pacemaker……………….…...	YES	NO	Hepatitis B (serum)……………………...	YES	NO
Heart Surgery……………………..….	YES	NO	Hepatitis C…………………...………	YES	NO
Artificial Joints / Replacements…...	YES	NO	Liver Disease……………………..…….	YES	NO
Anemia……………………..…….	YES	NO	Yellow Jaundice…………………..…….	YES	NO
Stroke…………………………......	YES	NO	Blood Transfusion………………...……..	YES	NO
Kidney Trouble……...…………….	YES	NO	Hemophilia……………………………...	YES	NO
Ulcers……………………………...	YES	NO	Drug Addiction………………………….	YES	NO
Mental Retardation………………....	YES	NO	Venereal/Sexually Transmitted Disease...	YES	NO
Emphysema………………………..	YES	NO	Syphilis, Gonorrhea……………….…….	YES	NO
Cough……………………..……..	YES	NO	Cold Sores/Fever Blisters………..…….	YES	NO
Tuberculosis (TB)..………………..	YES	NO	Herpes…………………………………...	YES	NO
Asthma…………………………	YES	NO	Epilepsy or Seizures…………………….	YES	NO
Other Respiratory Illness……….….	YES	NO	Fainting or Dizzy Spells………...…….	YES	NO
Hay Fever……………………..…..	YES	NO	Headaches……………………………….	YES	NO
Sinus Trouble……………………...	YES	NO	Nervousness…………………………….	YES	NO
Allergies or Hives………………...	YES	NO	Psychiatric Treatment…………………...	YES	NO
Diabetes…………………………...	YES	NO	Sickle Cell Disease……………………...	YES	NO
Thyroid Disease…………………….	YES	NO	Bruise Easily…………………………….	YES	NO

X-Ray or Cobalt Treatment……………... YES NO
Chemotherapy (Cancer, Leukemia)……... YES NO
Do you smoke or chew tobacco?............... YES NO
How Much?______________________

Allergies to Anesthetics……………… YES NO
Allergies to Drugs…………………….. YES NO
Chemical Dependency………………... YES NO
Cosmetic Surgery…………………….. YES NO

13. Have you lost or gained more that 10 pounds in the past year?.. YES NO
14. Are you on a special diet?.. YES NO
15. Do you have any disease, condition or problem not listed?... YES NO
If yes, please describe____
16. Do you feel very nervous about having dental treatment?... YES NO
17. How long has it been since your last dental appointment?_______________________________
18. Date of your last dental x-rays____
19. Name of your last dentist____
20. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Teeth sensitive to cold, heat sweets or pressure………... YES NO
Bleeding gums…………………..…. YES NO
Food Impaction…………………… YES NO
Clenching or Grinding…………… YES NO
Burning of Tongue……………….. YES NO
Swelling or lumps in mouth………. YES NO
Blisters on lips or mouth………….. YES NO
Pain around ear………..…………. YES NO
Unusual sounds in ear while eating. YES NO

Bad Breath……………………………….. YES NO
Unpleasant taste in mouth………………… YES NO
Unfavorable dental experience…………….. YES NO
Complications from extractions…………… YES NO
Periodontal Treatment (Gum Surgery)…….. YES NO
Orthodontic Treatment (Braces)…………... YES NO
Mouth Breathing…………………………... YES NO
Oral Habits (nail biting, cheek biting)……... YES NO
Gag Easily………………………………… YES NO
Frequent Headaches……………………….. YES NO

21. Do you use:
Dental Floss…………….... YES NO
Fluoride supplements or fluoride mouth rinse YES NO
Inter-dental stimulators (Stim-U-Dents)….. YES NO
Water jet device (water pic)……………….. YES NO

Do you use anything not listed above to clean between your teeth?... YES NO
22. How often do you brush your teeth?____
23. What is the texture of your toothbrush? ____
24. Are you aware of any growths or sores in or around your mouth?.. YES NO
25. Do you have any trouble chewing?... YES NO
26. Have you ever been told you have gum problems?... YES NO
27. Would you be interested in having whiter teeth?... YES NO
28. **WOMEN ONLY**:
Are you taking birth control pills?.. YES NO
Are you pregnant? If yes, what month?_______________________.................................... YES NO
Are you nursing?.. YES NO

29. Is there anything else we should know about your medical or dental history?
____
____
____

30. Pharmacy you prefer ___________________________________Phone_____________________

I understand the information on this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand this information will be held in strict confidence and it is my responsibility to inform this office of any changes in my medical status. The undersigned hereby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that my be indicated in connection with (Name of Patient)____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient Signature____Date_________/_________/________

For Office Use Only

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