Caminschi
DR. CAMINSCHI DENTISTRY

Medical & Dental History

Name: _____ Date: _____

Sex: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ Province:_____ Postal Code: _____

Home #: _____ Cell #: _____ Work #: _____

Please indicate phone # you prefer we contact you at? _____

Marital Status (please circle one): single married widowed separated divorced

If married *(for emergency purposes only)**:***
Spouse's name:_____
Phone # we can contact your spouse at: _____

Medical History

Your answers are for our record only and will be considered confidential.
Please answer them to the best of you knowledge. These facts have a direct bearing on your dental health.

Name of Physician: _____ Doctor's office #: _____

Date of last physical exam: _____

Please circle 'yes' or 'no', whichever applies, for the following questions.

1. Are you in general good health?..... Yes No
2. Has there been any changes in your general health within the last year?..... Yes No
3. Are you now under a physician's care?..... Yes No
   If yes, for what condition? _____
4. Have you had any serious illness or operation?..... Yes No
   If yes, please list: _____
5. Have you been hospitalized or had a serious illness within the past 5 years?..... Yes No
   If yes, what reason? _____

Cardiovascular system

1. Do you have or have you ever had any of the following:
Heart trouble Heart attack Stroke
Damaged heart valves Congenital heart disease
Coronary insufficiency None

2. Rheumatic heart disease or heart murmur?..... Yes No

3. Chest pain after exertion?..... Yes No

4. Do you have a cardiac pacemaker?..... Yes No

5. Do you have any blood pressure problems?..... Yes No
High _____ Low _____

Respiratory System

1. Do you have or have you ever had Tuberculosis?..... Yes No

2. Is there any history of Tuberculosis in your family?..... Yes No

3. Do you have any sinusitis or sinus trouble?..... Yes No

4. Do you have Emphysema, Chronic Bronchitis or Asthma?..... Yes No

hematopoietic system

1. Do you have Anaemia, Sickle cell disease or any blood disorders?..... Yes No

2. Are you haemophilic?..... Yes No

3. Have you had abnormal bleeding after surgery, extraction, or trauma?..... Yes No

4. Have you ever had a blood transfusion?..... Yes No

Genitourinary system

1. Do you have or have you ever had kidney trouble?..... Yes No
2. Have you been exposed to the HIV virus?..... Yes No
3. Do you have AIDS?..... Yes No

Central Nervous system

1. Do you have or have you ever had:
a. epilepsy..... Yes No
b. fainting spells..... Yes No
c. seizures..... Yes No
d. emotional disturbances..... Yes No

2. Do you follow any treatment for a nervous disease?
Yes No

Digestive system

1. Do you have any stomach ulcers? ..... Yes No

2. Do you have or have you ever had:
a. hepatitis..... Yes No
b. jaundice..... Yes No
c. liver disease..... Yes No

endocrine system

1. Do you have Diabetes?..... Yes No

2. Do you have hypothyroidism?..... Yes No

3. Do you have hyperthyroidism?..... Yes No

Allergies

1. Are you allergic to or have you acted adversely to:
a. Local anaesthetics..... Yes No
b. Antibiotics, Penicillin, or Sulpha drugs.... Yes No
c. Barbiturates, sedatives, or sleeping pills.. Yes No
d. Aspirin..... Yes No
e. Codeine or other narcotics..... Yes No
f. Other..... Yes No

2. Do you have Asthma or Hay Fever?..... Yes No

3. Do you have or have you ever had hives or a skin rash?..... Yes No

If you have answered yes to any of the allergy questions, please provide more information:

_____

_____

Bone & joints

1. Do you have:

a. Arthritis..... Yes No
b. Inflammatory Rheumatism..... Yes No
c. Bone Infection..... Yes No
d. Osteoporosis..... Yes No

Miscellaneous

1. Are you wearing, or do you wear contact lenses?..... Yes No

2. Do you drink alcohol?..... Yes No
If yes, how much and how often? _____

3. Do you smoke or use tobacco?..... Yes No
If yes, how much and how often? _____

women

1. Are you pregnant?..... Yes No

2. Are you nursing?..... Yes No

3. Are you taking oral contraceptives or hormonal therapy?..... Yes No

neoplasms

1. Do you have or have you ever had:

a. Tumours or malignancies..... Yes No
b. Chemotherapy or Radiation Therapy Yes No

Medications

1. Are you taking any of the following medications?

a. Antibiotics or sulfa drugs..... Yes No
b. Anticoagulants (blood thinners)..... Yes No
c. Medicine for high blood pressure..... Yes No
d. Tranquilizers..... Yes No
e. Codeine or other narcotics..... Yes No
*f. Other:*_____

If you are taking any medications, please give details of the name of the medications, the dose, frequency, and the reason for use:

_____
_____
_____
_____

Dental History

1. What is your chief complaint about your teeth?
   _____
   _____

2. How would you like us to help you?
   _____
   _____

3. Are you experiencing any discomfort or pain at this time?..... Yes No
4. Are you satisfied with the appearance of your teeth?..... Yes No
5. Are you able to eat and chew foods satisfactorily?..... Yes No
6. Do you have headaches, earaches, or neck pain?..... Yes No
7. Do you have any problems with your jaw joints?..... Yes No
8. Do you have any problems with your bite?..... Yes No
9. Have you had serious trouble associated with previous dental treatment?..... Yes No
   If yes, please explain
   _____

Denture Patients

1. Do you wear partial or complete dentures?..... Yes No
If yes, what do you have and when were they made?
_____

2. Do your dentures move during function?..... Yes No

3. Do your dentures hurt?..... Yes No

4. Can you eat properly with your dentures?..... Yes No

5. Do your dentures drop and cause social embarrassment?..... Yes No

6. Are you satisfied with your facial appearance? Yes No

7. Are they satisfactory?..... Yes No

Please expand on any problems and indicate any other denture concerns that you may have:
_____
_____

Additional Information

Is there anything in your medical and dental history that we have not specifically asked about that we should be aware of?..... Yes No
If so, please explain
_____
_____
_____

Consent

I, _____ hereby authorize and request the performance of dental services for myself or for _____.

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by Dr. Genoveva Caminschi and her supervised staff for diagnostic purposes or dental treatment.

The records may include study models, photographs and x-rays, which may be used for dental education and used in dental publications.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named regardless of insurance coverage.

I also understand that the treatment estimated presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment and its fee.

I believe the information given in the pages of this medical and dental history to be true to the best of my knowledge.

Signature of patient/guardian: _____

Signature of Doctor: _____

Date: _____