ALEXANDER HAKIM, D.M.D.

PATIENT INFORMATION AND HEALTH HISTORY

Name _____ Date of Birth _____

Home Address _____ City _____ Zip _____

Soc. Security No. _____ Driver's Lic. No. _____ Telephone _____

Marital Status _____ Name of Spouse _____

Patient's Occupation _____ Firm _____

Business Address _____ Telephone _____

Spouse's Occupation _____ Firm _____

Business Address _____ Telephone _____

Referred by _____ Emergency Contact _____

Patient's Dentist _____

How long have you been a patient of your present dentist? _____

Name of Dental Insurance Company (if any) _____

MEDICAL HISTORY

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
   Date of last medical exam? _____ Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain _____
2. Yes No Are you in pain now?
   If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING (Please Circle)

Chest Pain (Angina)
Fainting spells
Recent significant weight loss
Fever
Night sweats
Persistent cough
Coughing up blood
Bleeding problems
Blood in urine
Blood in stools
Diarrhea or constipation
Frequent urination
Difficulty urinating
Ringing in ears
Headaches
Dizziness
Blurred vision
Bruise easily
Frequent vomiting
Jaundice
Dry mouth
Excessive thirst
Difficulty swallowing
Swollen ankles
Joint pain or stiffness
Shortness of breath
Sinus problems

Women: Do you have any of the following conditions? (check box)

❑ Pregnancy ❑ Birth Control Pills ❑ Menopause ❑ Nursing ❑ Menstrual Problems

Root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

Signature: _____ Date: _____

III. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	TMJ	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects	Tumors or cancer	Sexually transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal
Sulfa Drugs	Others _____	

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational Drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

VI. PLEASE LIST ANY ADDITIONAL MEDICATIONS: _____

VII. ALL PATIENTS

Yes No Do you have or have had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes No Have you ever been pre-medicated for dental treatment? If YES, why _____

Yes No Have you ever taken Fen-Phen? If YES, when _____

Yes No Is there any issue or condition that you would like to discuss with the dentsit in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Futher, 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 the completion of this form.

_____

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**