THE Dental Practice OF LINCOLN PARK

Dr. Allen P. Momongan, DDS

General & Cosmetic Dentistry
1439 W. Fullerton - Chicago, IL 60614

PATIENT'S NAME: _____
LAST FIRST INITIAL DATE OF BIRTH

MEDICAL HISTORY

1. Physician's Name_____ Phone ( )_____
Have you ever had any medical care?..... Yes No
Describe_____
2. Are you currently taking any prescription medication or drugs?..... Yes No
If yes, please list name and dosage_____
_____
3. Are you currently taking any herbal remedies, over the counter medication, or vitamins?..... Yes No
If yes, please list name and dosage_____
4. Have you been a patient in the hospital during the past five years?..... Yes No
5. Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐Sulfa Drugs
☐Other If yes, please specify_____

6. Indicate which of the following you have had, or currently have. Circle "Yes" or "No" to each item.

Heart(Surgery,Disease,Attack)	Yes	No	Contact Lenses	Yes	No
Chest Pain	Yes	No	Emphysema	Yes	No
Congenital Heart Disease	Yes	No	Chronic Cough	Yes	No
Heart Murmur	Yes	No	Asthma	Yes	No
High/Low Blood Pressure	Yes	No	Hay Fever/Allergy/Hives	Yes	No
Mitral Valve Prolapse	Yes	No	Sinus Trouble	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Radiation Therapy	Yes	No
Rheumatic Fever	Yes	No	Chemotherapy	Yes	No
Arthritis/Rheumatism	Yes	No	Tumors	Yes	No
Corisone Medicine	Yes	No	Hepatitis A B C (circle)	Yes	No
Swollen Ankles	Yes	No	Venereal diseases	Yes	No
Stroke	Yes	No	A.I.D.S/H.I.V Positive	Yes	No
Diet (Special/Restricted)	Yes	No	Cold sores/Fever Blisters	Yes	No
Artificial Joints(hip,knee,etc.)	Yes	No	Hemophilia	Yes	No
Kidney Trouble	Yes	No	Bruise Easily	Yes	No
Ulcers	Yes	No	Neurological Disorders	Yes	No
Diabetes	Yes	No	Epilepsy or Seizures	Yes	No
Thyroid Problems	Yes	No	Fainting or Dizzy Spells	Yes	No
Glaucoma	Yes	No	Psychiatric/Psychological	Yes	No
Nervous/Anxious	Yes	No	Cancer	Yes	No
Sickle Cell Disease	Yes	No	Liver Disease/Yellow Jaundice	Yes	No

7. Do you have or have had any diseases, conditions, or problems not listed?..... Yes No
If yes, please list_____
8. **Women:** Are you pregnant or think you could be pregnant? Yes / No _____Months Nursing? Yes No
9. Do you use any birth control?..... Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN_____ Date_____

(PLEASE COMPLETE OTHER SIDE OF THIS SHEET)

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DENTAL HISTORY

1.What is the reason for your visit today?_____

_____

2.Date of Last Dental Visit?_____Date of Last Dental Cleaning?_____

3.What was done at your last dental visit? _____ X-rays taken?_____

4.Previous Dentist Name_____

Address_____Telephone_____

5.Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? Yes No

If yes, explain_____

5.How often do you have dental examinations? _____

6.How often do you brush your teeth?_____How often do you floss?_____

7.Have you ever used or are currently using any fluoride rinse?..... Yes No

8.Are there other dental aids that you use?(Waterpik,Sonicare,etc.)..…….... Yes No

9.Do you have any dental problems now?..... Yes No

If yes, describe_____

10. **Are any of your teeth sensitive to:**

☐Hot/Cold ☐Sweets ☐ Biting/Chewing ☐ Pressure

☐Other, please specify_____

11.**Do you or have you:**

Lost or had any teeth removed?	Yes	No
Have they been replaced?	Yes	No
How have they been replaced?		
☐Fixed bridge ☐Removable Bridge ☐Denture ☐Implant		
Date:_____		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco products?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
cold sores, blisters or any other oral lesions?	Yes	No

Breathe/sleep with mouth open?	Yes	No
Clicking or popping of the jaw?	Yes	No
Pain? (joint,ear,side of face)	Yes	No
Difficulty opening or closing the mouth?	Yes	No
Difficulty chewing on either side of mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles? (neck, shoulders)	Yes	No
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Endodontic treatment?	Yes	No

Do your gums bleed or hurt?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where _____		
Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Your teeth ground down or the bite adjusted?	Yes	No
A serious injury to the mouth or head?	Yes	No
If yes, please describe _____		
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to replace your silver fillings?	Yes	No
Would you like to whiten your teeth?	Yes	No

Do you have any other questions or concerns? Yes No

If yes, explain_____

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SIGNATURE OF PATIENT, PARENT or GUARDIAN_____ Date_____