DENTAL FITNESS, INC.
DR. EDITH OAMIL-PACHO DMD

DENTAL AND MEDICAL HISTORY FORM

As required by law, our office adheres to written and procedures to protect the privacy of information about you that we create or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you you will be asked some questions about your response to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Contact Information

Today's Date:

PATIENT: LAST NAME | FIRST NAME | MIDDLE NAME

Mailing address: Street:

City: State: Zip Code:

Telephone No.: Alternate Contact No.:

If you are completing this form for another person, what is your relationship to that person?

Your Name: Relationship:

PRIMARY REASON FOR THIS APPOINTMENT

☐ EXAMINATION ☐ EMERGENCY ☐ CONSULTATION ☐ OTHER:

1. DENTAL HISTORY

Do you have a specific dental problems? ☐ Yes ☐ No ☐ Don't know

Describe:

Do you have dental examination on a regular basis? ☐ YES ☐ NO

When is your last visit?

Previous Dentist

Would you describe your present dental health as good? ☐ YES ☐ NO

Comment:

Do you think you have active decay or gum disease? ☐ YES ☐ NO

Describe:

Do your gums ever bleed? ☐ YES ☐ NO

Describe:

Do you brush and floss on a routine basis? ☐ YES ☐ NO

How many times a day?

Do you feel nervous about having dental treatment? ☐ YES ☐ NO

Describe:

Have you ever had a bad experience in a dental office? ☐ YES ☐ NO

Describe

Do you want to keep your remaining teeth? ☐ YES ☐ NO

Do you like your smile? ☐ YES ☐ NO

Why?

What is the most important to you in dental care you receive?

What other dental information you want to share with Dr. Edith?

Describe:

2. MEDICAL HISTORY

Primary medical doctor's name : Phone No:

Are you under a doctor's care now? ☐ YES ☐ NO

Why?

Have you been hospitalize during the past two year? ☐ YES ☐ NO

Why?

Are you taking any medications, pills or drugs? ☐ YES ☐ NO

List all:

Pharmacy Name: Location

Are you Allergic to any medications or substances? ☐ YES ☐ NO

List all:

Do you wear contact lenses? ☐ YES ☐ NO

For women only

Are you pregnant? ☐ YES ☐ NO

How many months?

Are you nursing? ☐ YES ☐ NO

Are you taking birth control pills? ☐ YES ☐ NO

Please mark YES or NO that applies.

AIDS/HIV	☐ YES	☐ NO	Jaw Pain	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Kidney Disease	☐ YES	☐ NO
Arthritis, Rheumatism	☐ YES	☐ NO	Liver Disease	☐ YES	☐ NO
Artificial Heart valves	☐ YES	☐ NO	Low Blood Pressure	☐ YES	☐ NO
Artificial Joints	☐ YES	☐ NO	Mitral Valve Prolapse	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Nervous Problem	☐ YES	☐ NO
Back Problems	☐ YES	☐ NO	Pacemaker	☐ YES	☐ NO
Bleeding abnormally with extractions or surgery	☐ YES	☐ NO	Psychiatric Care	☐ YES	☐ NO
Blood Disease	☐ YES	☐ NO	Radiation Treatment	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Respiratory Disease	☐ YES	☐ NO
Chemical Dependency	☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO
Chemotherapy	☐ YES	☐ NO	Scarlet Fever	☐ YES	☐ NO
Circulatory Problem	☐ YES	☐ NO	Shortness of Breath	☐ YES	☐ NO
Congenital Hearth Lesions	☐ YES	☐ NO	Sinus Trouble	☐ YES	☐ NO
Cortisone Treatment	☐ YES	☐ NO	Skin Rash	☐ YES	☐ NO
Cough, Persistent or Bloody	☐ YES	☐ NO	Special Diet	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	Swollen Feet or Ankles	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO	Swollen Neck Glands	☐ YES	☐ NO
Fainting or Dizziness	☐ YES	☐ NO	Thyroid Problems	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO	Tonsillitis	☐ YES	☐ NO
Headaches	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO

Heart Murmur	☐ YES	☐ NO	Tumor or Growth on Head or Neck	☐ YES	☐ NO
Heart Problems	☐ YES	☐ NO	Ulcer	☐ YES	☐ NO
Hepatitis Type	☐ A	☐ B	Venereal Disease	☐ YES	☐ NO
Herpes	☐ YES	☐ NO	Weight Loss, Unexplained	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Sleeping Disorder	☐ YES	☐ NO
Jaundice	☐ YES	☐ NO	Smoke or Chew Tobacco	☐ YES	☐ NO

Have you ever had other illness not stated above? ☐ YES ☐ NO

Describe in detail: _____

Do you wish to talk to the doctor privately about any dental or health problem? ☐ YES ☐ NO

I have read and understand the Notice of Privacy Practices (rev. DFI 08-2016) and I can request a copy anytime in the front desk of Dental Fitness, Inc. Initial _____

Note: Both doctor and patient are encourage to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of truthful health history and that my dentist and her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Edith Oamil-Pacho and Dental Fitness, Inc. including her staff, responsible for any action they take because of errors or omissions that I may have made in the completion of this form.

Please signify your acceptance by entering the information requested in the fields below. By my e-Signature or signature below, I certify that I have read, fully understand and accept all terms of the foregoing statement.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

DFI dnt/med reg form rev 08-2016