Ihab Abboud, DDS
Leesburg Bright Dental

Dental History

Patient's Name: _____

Do you have a specific dental concern? Yes/No
If so, please describe _____

Have you had any periodontal (gum) treatments? Yes/No
If so, please describe _____

Do you like your smile? Yes/No
Please describe why or why not _____

Do you hear clicking or feel discomfort with your jaw? Yes/No

Do you clench or grind or teeth? Yes/No

Have your past dental experiences with a dentist been positive? Yes/No
If not, please describe _____

Do you smoke or chew tobacco? Yes/No
If so, describe frequency _____

Medical History

Are you currently under the care of a physician? Yes/No

If so, please describe _____

Physician's Name _____ Physician's Phone _____

Have you ever been hospitalized or had any major operations? Yes/No
If so, please describe _____

Have you ever had serious injury to your head or neck? Yes/No
If so, please describe _____

Are you currently taking any prescription medications, nonprescription drugs/substances or over the counter medications? Yes/No
If so, please list _____

Are you on a special diet? Yes/No
If so, describe _____

Date of last Health Care Exam. _____ Reason for Exam _____

Are you allergic to any medications or substances? Yes/No
If yes, please circle the following that pertain to you.

Sulfa Aspirin Penicillin Erythromycin Latex Codeine Nitrous Oxide Local Anesthetic

Female Patients Only – Please circle all that apply to you.

Pregnant Trying to get pregnant Nursing Taking oral contraceptives

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Medical History (Continued)

Do you have or have you had any of the following? If so, please circle all that apply.

Heart Disease/Surgery	Heart Murmur	Mitral Value Prolapse	Rheumatic Fever
Artificial Heart Valve	Frequent Diarrhea	Artificial Joint	Heart Pacemaker
Irregular Heart Beat	Angina/Chest Pain	Heart Attack/Failure	Congenital Heart Disorder
High Blood Pressure	Bacterial Endocarditis	Blood Disease	Anemia
Excessive Bleeding	Sickle Cell Disease	Hemophilia	Leukemia
Recent blood transfusion	Swelling of Limbs	Lung Disease	Shortness of Breath
Frequent Cough	Hay Fever	Sinus Trouble	Asthma
Bloody Sputum	Emphysema	Tuberculosis	Cancer
Radiation Treatments	Chemotherapy	Liver Disease	Hepatitis B or C
Hepatitis A (infectious)	Night Sweats	Yellow Jaundice	Kidney Problems
Renal Disease	Thyroid Disease	Arthritis	Venereal Disease
Parathyroid Disease	HIV/AIDS	Genital Herpes	Oral Herpes/Fever Blisters
Drug Dependency	Alcoholism	Diabetes	Excessive Thirst
Hypoglycemia	Tattoos/Body Piercing	Stroke	Epilepsy/Seizures
Fainting or Dizziness	Glaucoma	Psychiatric Care	Nervousness/Anxiety
Alzheimer's Disease	Migraines/Headaches	Auto-immune Disease	Need Premedications
Stomach/Intestinal	Ulcers/Colitis	Rapid Weight Gain/Loss	Osteoporosis
Have taken Fen-Phen			

Have you ever had any other serious illness not described above? If yes, please describe. _____

_____

To the best of my knowledge, all of the preceding answers are correct. If there are any changes to my health status or medications, I shall inform the dentist and staff at the next appointment.

Signature _____ **Print Name** _____

Relationship to Patient _____ **Date** _____

Doctor's Signature _____ Date _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient _____

Cell # _____ Home # _____ Work # _____

Name _____ Relationship to Patient _____

Cell # _____ Home # _____ Work # _____