Dr. Allen P. Momongan, DDS

THE Dental Practice OF LINCOLN PARK
General & Cosmetic Dentistry
1439 W. Fullerton Ave. Chicago, IL 60614

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

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

MEDICAL HISTORY

1. Physician's Name: _____
   Address _____
2. Are you under a physician's care?.....Yes / No
   Since when?_____ Why? _____
3. When was your last complete physical exam?_____
4. Are you taking any medication or substances?.....Yes / No
   (If yes, please list medications on back of this form)
5. Do you routinely take health related substances?.....Yes / No
6. Are you allergic to any medications or substances?.....Yes / No
7. Do you have any other allergies?.....Yes / No
8. Do you have any problems with penicillin, antibiotics, or other medications? .....Yes / No
9. Are you sensitive to any metals or latex?.....Yes / No
10. Are you pregnant or suspect you may be?.....Yes / No
11. Do you use any birth control medications?.....Yes / No
12. Have you ever been treated for or been told you might have heart disease?.....Yes / No
13. Do you have a pacemaker or an artificial heart valve implant?.....Yes / No
14. Have you ever had rheumatic fever?.....Yes / No
15. Are you aware of any heart murmurs?.....Yes / No
16. Do you have high or low blood pressure?.....Yes / No
17. Have you ever had a serious illness or major surgery?. Yes / No
    If so, explain:_____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?.....Yes / No
19. Do you have inflammatory diseases, such as arthritis or rheumatism?.....Yes / No
20. Do you have any artificial joints / prosthesis?.....Yes / No
21. Do you have any blood disorders, such as anemia, leukemia etc.?.....Yes / No
22. Have you ever bled excessively after being cut or injured?.....Yes / No
23. Do you have any stomach problems?.....Yes / No
24. Do you have any kidney problems?.....Yes / No
25. Do you have any liver problems?.....Yes / No
26. Are you diabetic?.....Yes / No
27. Do you have asthma?.....Yes / No
28. Do you have epilepsy or seizure disorders?.....Yes / No
29. Do you have or had venereal disease?.....Yes / No
30. Are you HIV positive?.....Yes / No
31. Do you have AIDS?.....Yes / No
32. Have you had or do you test positive for hepatitis?.....Yes / No
33. Do you have or had T.B.?.....Yes / No
34. Do you smoke, chew, use snuff or any other forms of tobacco?.Yes/No
35. Do you consume alcoholic beverages?.....Yes / No
36. Do you habitually use controlled substances?.....Yes/No
37. Have you had psychiatric treatment?.....Yes/No

DENTAL HISTORY

1. Purpose of initial visit _____
   _____
2. Are you aware of a problem? _____
   _____
3. How long since your last dental visit? _____
4. What was done at the time? _____
   _____
5. Previous dentist's name:_____
   Address_____ Ph. # _____
6. When was the last time your teeth were cleaned? _____
7. Have you made regular visits?.....Yes / No
   How Often?_____
8. Were dental x-rays taken?.....Yes / No
9. Have you lost any teeth or have any teeth been removed?.....Yes / No
   Why? _____
10. Have they been replaced?.....Yes / No
11. How have they been replaced? a. Fixed Bridge _____Age___
    b. Removable Bridge_____Age___
    c. Denture_____Age___
12. Are you unhappy with the replacements?.....Yes / No
    If yes, explain: _____
13. Would you like to know about permanent replacements?.....Yes / No
14. Have you ever had any problems or complications with previous dental treatment? If yes, explain: _____
15. Do you clench or grind your teeth?.....Yes / No
16. Does your jaw click or pop?.....Yes / No
17. Have you experienced any pain or soreness in the muscles on your face or around your ear?..... Yes / No
18. Do you have frequent headaches, neck, shoulder aches?.....Yes / No
19. Does food get caught in your teeth?.....Yes / No
20. Are any of your teeth sensitive to:__Hot __Cold __Sweets __ Pressure?
21. Do your gums bleed or hurt? ……..……Yes / No
    When?_____
22. How often do you brush your teeth?_____When?_____
23. Do you use dental floss?.....Yes / No…How Often?_____
24. Are any of your teeth loose, tipped, shifted or chipped?.....Yes / No
25. Are you unhappy with the appearance of your teeth?.....Yes / No
26. How do you feel about your teeth in general?_____
27. Do you feel your breath is offensive at times?.....Yes / No
28. Would you like to whiten your teeth?.....Yes / No
29. Have you ever had gum treatment or surgery?.....Yes / No
    What?_____Where? _____When? _____
30. Have you had any orthodontic work?.....Yes / No
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
32. Do you have any questions or concerns?.....Yes / No

_____**PLEASE CHECK:** **FOR COMMENTS ON BACK OF SHEET.**

38. Do you have any disease, condition, or problem not listed? If so, explain: _____
39. Is there anything else we should know about your health that we have not covered in this form? _____
40. Would you like to speak to the Doctor privately about any problem? .....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** _____
Dentist's Signature _____ **Date:** _____