GALINDO PROSTHODONTICS

DANIEL F. GALINDO, D.D.S., P.C.

Board Certified by the American Board of Prosthodontics

MEDICAL HISTORY

Patient Name: _____ Date: _____

Last, First MI (Preferred Name)

Primary reason for this dental appointment: ☐ **Consultation** ☐ **Examination** ☐ **Emergency**

Medical Doctor's Name & Address: _____ Phone Number: _____

Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain: _____

Have you been hospitalized or had major surgery? ☐ Yes ☐ No If yes, please explain: _____

Have you had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any **medications, pills or drugs**? ☐ Yes ☐ No If yes, enter below: _____

Do you take or have you taken **Phen-Fen / Redux**? ☐ Yes ☐ No _____

Do you take or have you taken **Zometa / Fosamax**? ☐ Yes ☐ No _____

Do you smoke or use other tobacco products? ☐ Yes ☐ No _____

Do you use controlled substances? ☐ Yes ☐ No _____

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine
☐ Acrylic ☐ Metal ☐ Latex
☐ Local Anesthetic ☐ Other:

If yes to any, please explain: _____

Women: Are you ☐ Pregnant or trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

CURRENT MEDICATIONS

Please provide a complete list and description of any medication you are presently taking.

_____

_____

_____

_____

_____

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my health.

_____ Date: _____ Reviewed _____

Signature of patient, parent or guardian

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HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores / Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells / Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack / Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble / Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Spina Bifida
- ☐ Stomach /Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

OTHERS

Please provide a complete description to include nature of illness, when occurred and treating physician. Provide contact information and/or address of all treating physicians or hospitals.

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DENTAL HISTORY

Date of Last Dental Visit: _____ Reason for this Visit: _____

Are you having any discomfort on your teeth? ☐ Yes ☐ No If yes, please explain: _____

Are your teeth sensitive to hot or cold? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No If yes, please explain: _____
Jaw surgery? ☐ Yes ☐ No If yes, please explain: _____
Periodontal treatment? ☐ Yes ☐ No If yes, please explain: _____
Your occlusion (bite) adjusted? ☐ Yes ☐ No If yes, please explain: _____
Worn an occlusal (bite) guard? ☐ Yes ☐ No If yes, please explain: _____

Are your teeth loose? ☐ Yes ☐ No Does food lodge between your teeth? ☐ Yes ☐ No

Are your gums painful or swollen? ☐ Yes ☐ No Do they bleed when you brush? ☐ Yes ☐ No

Do you snore or do you suffer from sleepiness due to a sleep disorder, such as obstructive sleep apnea? ☐ Yes ☐ No
If yes, please explain: _____

Do you clench or grind your teeth? ☐ Yes ☐ No Do you bite your lips or cheeks? ☐ Yes ☐ No

Are you experiencing problems with your jaw joint?

Clicking of the joint? ☐ Yes ☐ No If yes, please explain: _____
Pain (joint, ear, side of face)? ☐ Yes ☐ No If yes, please explain: _____
Difficulty opening or closing? ☐ Yes ☐ No If yes, please explain: _____
Difficulty chewing? ☐ Yes ☐ No If yes, please explain: _____

Are you now under the care of a general dentist? ☐ Yes ☐ No If yes, please explain: _____
Name of Dentist: _____ Address: _____ Telephone: _____

Have you ever had any complication following dental treatment? ☐ Yes ☐ No If yes, please explain: _____

Are you happy with the appearance of your teeth? ☐ Yes ☐ No If no, please explain: _____

Are you interested in whitening your teeth? ☐ Yes ☐ No If yes, please explain: _____

Are there any constraints that may severely limit your needed treatment? ☐ Yes ☐ No If yes, please explain: _____

I hereby grant my permission to Dr. Daniel F. Galindo to administer anesthetic or other drugs or pharmaceuticals, to remove any tissue or structure, to use such operative and technical procedures necessary to complete a diagnosis and/or recommend treatment, and to accept the sequence in which the diagnosis and treatment plan will be accomplished. I also grant my permission to acquire and use all or any part of my records, photographs, videos, radiographs, images which may be required for examination, diagnosis, treatment and/or scientific presentation.

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