

Medical/Dental History

We understand you are here for us to help you care for your teeth and gums, however, medication you are taking, and health conditions you have could make a difference in how we treat your dental problems. This information is very important; it is also confidential. Thank you in advance for your cooperation. Dr. Kagan & Team.

Have you ever had any of the following:

(Please circle your answers)

Cancer / Radiation / Chemotherapy
High / Low Blood Pressure
Congenital Heart Disease
Stroke / Heart Attack
Heart Surgery other than Bypass
Previous Endocarditis
Anemia / Hemophilia / Abnormal Bleeding
Severe or Frequent Headaches
Psychiatric Problems
Fever Blisters / Shingles / Cold Sores
Epilepsy / Seizures / Fainting Spells
Tuberculosis (TB)
Ulcers / Colitis
Drug / Alcohol Abuse
Venereal Disease
Blood Transfusion
Kidney Problems

Diabetes
HIV / AIDS
Hepatitis A, B, C, or Delta / Liver Dx
Lupus
Organ Transplant
Arthritis
Osteoporosis
Artificial Bones / Joints
Neuromuscular Disorder
Asthma
Sinus Problems / Allergies
Lung Surgery
Emphysema
Bronchitis
Difficulty Breathing
Thyroid Problems
Glaucoma

- Are there any other medical concerns that we should know about? _____
- What is the primary reason for this dental appointment? _____
- Are you allergic to any medications or substances (including latex)? _____
- Are you currently taking any medication? Yes No If so, which: _____
- Are you taking sexual enhancement drugs? Yes No If so, which: _____
- Are you currently under a physician's care? Yes No Why? Who?: _____
- Are you pregnant? Yes No • Are you taking contraceptives? Yes No
- Are you currently in pain? Yes No • Do you smoke? Yes No
- Check choices that apply to you: Cavities Sensitive teeth Bad breath or taste Bleeding gums
- Have you ever thought about changing the color or shape of your teeth? Yes No
- What is most important to you about your dental health? Health Appearance Longevity Function
- What is most important to you about your relationship with a dentist?
 Competence Bedside Manner Knowledge Friendliness Sense of Humor
Other: _____
- What did you like / dislike about your past dental appointments?
 Treatment Uncomfortable Staff Fee concerns Cleanliness
Other: _____
- Does dental treatment make you nervous? Yes No Would you like to be asleep during dental treatment? Yes No
- If we could come up with a plan that would keep your teeth strong and healthy for a lifetime, is this something you would be interested in learning about? Yes No
- I Authorize discussion of my dental treatment and finances with _____