Dr. Harvey Levy & Associates

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MEDICAL HISTORY

Patient Name: _____ * _____ * _____ _____

Last First MI Preferred Name

How would you rate your general health?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Indicate which of the following conditions you currently have, or have had in the past. Check a box to mean "YES". Leave a box blank to mean "NO".

- ☐ Acid Reflux
- ☐ ADD/ADHD
- ☐ Allergy - Augmentin
- ☐ Allergy - Cipro
- ☐ Allergy- Amoxicillin
- ☐ Allergy- Anesthetic
- ☐ Allergy- Aspirin
- ☐ Allergy- Benzocaine
- ☐ Allergy- Clindamycin
- ☐ Allergy- Codeine
- ☐ Allergy- H2O2
- ☐ Allergy- Ibuprofen
- ☐ Allergy- Latex
- ☐ Allergy- Nickel
- ☐ Allergy- Novocain
- ☐ Allergy- Other
- ☐ Allergy- Penicillin
- ☐ Allergy- Percocet
- ☐ Allergy- Sulfa Drugs
- ☐ Allergy- Tylenol
- ☐ Allergy-Azithromycin
- ☐ Allergy-Erythromycin
- ☐ Allergy-Tetracycline
- ☐ ALS
- ☐ Anemia
- ☐ Anxiety (Dental)
- ☐ Anxiety (General)
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autism
- ☐ Blood Disease
- ☐ Blood Pressure High
- ☐ Blood Pressure Low
- ☐ Blood Thinner
- ☐ C. Dif.
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chronic Bronchitis
- ☐ Cong. Heart Failure
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Deafness
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Disability-Intel/Dev
- ☐ Down's Syndrome
- ☐ Dystonia
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ GERD
- ☐ Hard of Hearing
- ☐ Heart Condition
- ☐ Heart Valve Replaced
- ☐ Hepatitis
- ☐ Herpes I or II
- ☐ HIV/AIDS
- ☐ HPV
- ☐ Liver Disease
- ☐ Major Surgery
- ☐ Mental Disorders
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ NO Epinepherine
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Pacemaker/ICD
- ☐ Parkinson's Disease
- ☐ Pre-Med Antibiotic
- ☐ Prolonged Bleeding
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Special Needs
- ☐ Spinal Stimulator
- ☐ Stent
- ☐ Stroke
- ☐ Swallowing Problems
- ☐ Thyroid Disorder
- ☐ Trigeminal Neuralgia
- ☐ Tuberculosis
- ☐ Vertigo

FEMALES ONLY:

☐ Pregnant ☐ Planning pregnancy ☐ Nursing

☐ Hormonal birth control (pill, patch, injection, ring)

☐ ***I attest that I have read all the checkboxes above, and that if all of them were blank I assert that I have none of the conditions listed.**

If needed, please explain/clarify any medical conditions selected above:

_____

_____

_____

Do you have any allergies not listed above (including allergies to medications)? If yes, please list below: * ◯ Yes ◯ No

ALLERGIES. Please enter N/A if none: *

Do you have any of the following autoimmune disorders? *

☐ None ☐ Celiac Disease ☐ Lupus ☐ Rheumatoid Arthritis ☐ Sjogren's Syndrome ☐ Other

If Other, please explain. If None, please write N/A: *

Have you had an orthopedic replacement (hip, knee, joint, etc.)? If YES, what year and what body part? Any complications since then? Please provide information below. *

◯ Yes ◯ No

ORTHOPEDIC REPLACEMENT. Please enter N/A if none: *

Do you take antibiotic premedication for your dental visits? If yes, please list medication below. If no, please write N/A: * ◯ Yes ◯ No

PRE MED: *

What hospitalizations have you had in the past 5 years? Please start with the most recent. *

How much/often do you smoke, vape, or use chewing tobacco? *

Describe any current medical treatments, impending surgeries, or other treatments that may possibly affect your dental treatment. If none, please write N/A. *

Name and phone number of your physician and your most recent physical exam: *

Are you taking any prescription medications? If yes, please list all medications and dosages below. If no, please write N/A in the box below. *

Are you taking any non-prescription (over-the-counter) medications or supplements, including Aspirin? If yes, please list all medications and dosages. If no, please write N/A in the box below. *

Any other medical information the doctor should be aware of? *

Name, phone number, and location of your preferred pharmacy: *

DENTAL HISTORY

What is the reason for your scheduled visit? *

How would you rate the condition of your mouth? *

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Are you currently a patient at Dr. Harvey Levy & Associates?
If YES, skip the next two questions.
If NO, please answer the next two questions. * ◯ Yes ◯ No

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every: *

◯ 3 mo. ◯ 4 mo. ◯ 6 mo. ◯ 12 mo. ◯ Not routinely

Is there anything about the appearance of your smile that you would like to change?

Do you like the color of your teeth? * ◯ Yes ◯ No

I, or the patient... (check all that apply):

- ☐ Had complications from past dental treatment
- ☐ Had a reaction to local anesthetic
- ☐ Require sedation for dental work
- ☐ Have gums bleed when brushing or flossing
- ☐ Have teeth sensitive to hot, cold, biting, sweets
- ☐ Get food trapped between my teeth
- ☐ Experienced popping and/or clicking of jaw joint
- ☐ Clench or grind my teeth
- ☐ Wear, or have worn, a bite appliance
- ☐ Was diagnosed and/or treated for gum disease
- ☐ Noticed an unpleasant taste or odor in my mouth
- ☐ Have loose teeth (without injury)
- ☐ Snore, or wake up frequently during the night
- ☐ Have dental implants
- ☐ Have had trouble getting numb
- ☐ Have a fear of dentistry
- ☐ Had/have braces, orthodontic treatment
- ☐ Experience dry mouth
- ☐ Avoid brushing any part of my mouth
- ☐ Have whitened or bleached my teeth
- ☐ Have difficulty chewing
- ☐ Had/have ear pain
- ☐ Have gums bleed when brushing or flossing
- ☐ Have been told I have bone loss around my teeth
- ☐ Have been told I have gum recession
- ☐ Am experiencing a burning sensation in my mouth
- ☐ Wear removable dentures

If any of the checked boxes need further explanation, please describe:

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

If filling out a paper copy of this form, please sign:

Response Date: _____