Andrew Z. Green DDS

Medical Health History

Please check any boxes of conditions you have had or currently have.

Conditions

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV+ Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other

Y N

❑ ❑ Do you Smoke or use Tobacco?

If Female

Y N

❑ ❑ Are you taking Birth Control Pills?

❑ ❑ Are you pregnant? If yes, # of weeks

❑ ❑ Are you Nursing?

Have you been in the hospital recently? __ For what? ____

Have you had any complications during surgeries? __ What? ____________________________________

Please list any medications you are taking. ____

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Please list over the counter and herbal medications you are taking. ________________________________

Dental History

Are you having any pain or discomfort at this time?	Yes	No
Are you nervous about having dental treatment?	Yes	No
Do you have difficulty or pain when opening your mouth wide?	Yes	No
Does your jaw get stuck, locked, or go out?	Yes	No
Are you aware of any noises in the jaw joint?	Yes	No
Do you have pain in the area from your temple to your ears?	Yes	No
Do you have frequent headaches?	Yes	No
Have you recently had an injury to your head, neck, or jaw?	Yes	No
Have you ever had treatment for a jaw joint problem?	Yes	No
Have you ever had braces?	Yes	No
Do your gums bleed when you brush?	Yes	No
Are you happy with your smile?	Yes	No

What brings you in today? ________________________________