



# Dental Solutions

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### MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

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.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Women: Are you Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| Alzheimer's Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures      | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles / Herpes Zoster   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis (T.B.)        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pace Maker          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice            | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Comments: \_\_\_\_\_

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 \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF DENTIST \_\_\_\_\_ DATE \_\_\_\_\_

# MEDICAL HISTORY CONTINUED

Are you taking any medications, pills, or drugs? Yes No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? Yes No (If so, when? \_\_\_\_\_)

Do you use tobacco? Yes No  
If so, do you Smoke? Yes No How Much? \_\_\_\_\_

Do you Chew Tobacco? Yes No How Much? \_\_\_\_\_

Do you use controlled substances? Yes No

Do you consume alcohol? Yes No  
If so, how much per day / week / month? \_\_\_\_\_

Have you every had psychiatric treatment? If so, please explain \_\_\_\_\_  
\_\_\_\_\_

Have you ever had any serious illness not listed above? Yes No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you like to speak to the Doctor privately about any problems or conditions? Yes No

**Physicians Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

Please list below, any medications you are currently taking and dosing: (Please use the back of this page if necessary)

Medication \_\_\_\_\_ Dosing \_\_\_\_\_ Instructions \_\_\_\_\_

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