Malinoski & Associates, D.D.S., P.C.
717 Health Parkway
Three Rivers, MI 49093
(269)279-7876

NAME ______________________________

D.O.B. ______________________________

PHONE ______________________________

ADDRESS ______________________________

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HEALTH & DENTAL HISTORY

1. Are you satisfied with the present condition of your smile?............ YES NO
2. Are you satisfied with the present condition of your gums?............ YES NO
3. Are you satisfied with the present condition of your teeth?............ YES NO
4. Are you having dental pain or discomfort at this time?............ YES NO
   How would you describe this pain?______________________________
5. Has your physician ever requested you to take an antibiotic before dental treatment?............ YES NO
   Which antibiotic and reason why?______________________________
6. Have you been a patient in the hospital during the past two years?............ YES NO
7. Have you been under the care of a medical doctor during the past two years?............ YES NO
   If yes, for what?______________________________
8. Please provide Physician's name______________________________
   Address ______________________________Phone#______________
9. Are you now taking any medications, drugs or pills?............ YES NO
   If yes, please list:______________________________
10. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?............ YES NO
    If yes, please list:______________________________
11. Are you aware of any growths or sores in or around your mouth?............ YES NO
12. Do you have any trouble chewing?............ YES NO
13. Have you ever been told you have gum problems and or gum disease?............ YES NO
14. Would you be interested in whiter teeth?............ YES NO
15. Do you use:
    Dental Floss.........YES NO
    Fluoride supplements or fluoride mouth rinse.......YES NO
    Electric Toothbrush......YES NO
    If YES, what kind?______________
16. How often to you brush? ______________ Floss?______________
17. Do you feel nervous about having dental treatment?. .... YES NO
18. Do you have any teeth sensitive to cold, heat, sweets or pressure?............ YES NO
19. Do you have an ALLERGY TO LATEX?............ YES NO
20. Are you involved in any athletic activities?............ YES NO
21. When was your last dental visit (**new patients only**)______________________________
    Name of your previous Dentist: ______________________________
22. Is there anything else we should know about your medical or dental history?

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Pharmacy you prefer ______________________________Phone______________

WOMEN ONLY:

Are you taking birth control pills?............ YES NO
Are you pregnant?......YES NO If yes, what month?______________
Are you nursing? .... YES NO

****** Please complete other side ******

Indicate which of the following you have had or have at present. Circle all that apply.

Arthritis
Glaucoma
Scarlet Fever
Rheumatic Fever
Anemia
Epilepsy or Seizures
Hemophilia
Immuno Suppressive Disorder

Eating Disorder
Thyroid Problems
Diabetes
Headaches/Migraines
Dizzy Spells/Fainting
Abnormal Bleeding

AIDS / HIV
Hepatitis
TB (Tuberculosis)
Liver Disease
Jaundice
Kidney Trouble
G.E. Reflux/Heartburn
Ulcers
Gastrointestinal Disease

Nervousness
Mental Health Disorder
Chemical Dependency
Smoke / Chew Tobacco
Cortisone Medicine
Back Problems
Cancer—Chemotherapy / Radiation
Neurological Disorder
Osteoporosis

Heart Attack
Heart Surgery
Stroke
Hemophilia
Blood Transfusion
Heart Murmur
Heart Pacemaker
Congestive Heart Failure
Damaged Heart Valve
Congenital Heart Condition
Prolapsed Mitral Valve
High or Low Blood Pressure
Angina Pectoris
High Cholesterol
Arteriosclerosis
Coronary Artery Disease

Gag Easily
Bleeding Gums
Food Impaction
Clenching or Grinding
Burning of Tongue
Bad Breath
Unpleasant taste in mouth
Unfavorable dental experience
Complications from Extractions
Periodontal Treatment (gum surgery)
Orthodontic Treatment (Braces)
Pain in or around ear
Unusual sounds in ear while eating
Blisters on lips or in mouth

Oral Habits (nail or cheek biting)
Swelling or lumps in mouth
Mouth breathing
Dry Mouth
Emphysema
Asthma
Allergies or Hives
Allergies to Anesthetics
Hay Fever / Sinus Trouble
Swollen Neck Glands
Cough
Other Respiratory Illness
Artificial Joints / Replacement
Chronic Pain
Recurrent Infections

I understand the information on this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand this information will be held in strict confidence and it is my responsibility to inform this office of any changes in my medical status. The undersigned herby authorizes Doctor and his staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated, with your consent, in connection with (Name of Patient)____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient Signature ____Date ______________________________

FOR OFFICE USE ONLY

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