ghareebdentalgroup.com

POCA	SOUTH CHARLESTON	CROSS LANES	ST. ALBANS	TEAYS VALLEY
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Dr. Sami Ghareeb Dr. Azita Misaghi Dr. Steven Ghareeb Dr. Mitri Ghareeb Dr. Matthew Scarberry Dr. Kayla Buchanan Dr. Joshua Massey Dr. Carson Henley Dr. Lon Spain

HEALTH HISTORY

Patient Name: ____Today's Date: ______________________

In Case of Emergency, Please Contact: ____

Relationship to Patient: ______________________________ Emergency Phone Number: _______________________________

Physician Name: ______________________________________ Physician's Phone Number: ___________________________

Date of last exam? ________________ Are you currently under medical treatment? **Y / N** If so, for what? __________________

Have you been hospitalized within the last 5 years? **Y / N** If so, for what reason? ____

Have you had joint replacement surgery? **Y / N** If so, what kind and when? ____

Have you had heart surgery? **Y / N** If so, what kind and when? ____

Have you previously been diagnosed with bacterial endocarditis? **Y / N** If so, when? ___________________________________

Have you previously been diagnosed with ulcerative colitis? **Y / N** If so, when? _______________________________________

Have you been advised by a doctor to take antibiotics prior to dental treatment? **Y / N** If so, for what? ______________________

Are you a diabetic? **Y / N** If so, last blood sugar reading? ______________ When? ____________ Last HbA1c? ____________

Do you use tobacco? **Y / N** If so, what kind of tobacco do you use/how many packs a day? ______________________________

Do you drink alcohol? **Y / N** If so, how many drinks a day? ____

Do you use controlled substances? **Y / N** Do you use recreational drugs? **Y / N**

Are you pregnant or think you may be pregnant? **Y / N** Are you currently on birth control? **Y / N** Are you nursing? **Y / N**

Are you allergic to any medications? **Y / N** If so, which ones? ____

Are you currently taking blood thinners (aspirin, warfarin, etc.)? **Y / N** If so, which one and frequency? ____________________

Please list all other allergies: ____

Please include a list of **ALL** medications: ____

____

Do you have or have you had any of the following? Please circle.

Alzheimer's	Diabetes	Hepatitis	Respiratory Problems
Anemia	Diarrhea	High Blood Pressure	Rheumatic Fever
Arthritis	Dizziness and Fainting	HIV or AIDS	Shortness of Breath
Artificial Joints	Easily Winded	Immune Disease	Sinus Problems
Artificial Heart Valve	Emphysema	Kidney Disease	Stomach Ulcers
Asthma	Epilepsy	Latex Rubber Allergy	Intestinal Problems
Blood Disease	Excessive Bleeding	Liver Disease	Stroke
Bronchitis	Glaucoma	Low Blood Pressure	Swollen Ankles
Cancer/Chemotherapy	Growths	Mental/Nervous Disorders	Thyroid Problems
Chest Pain	Head Injuries	Mitral Valve Prolapse	Tuberculosis
Crohn's Disease	Heart Attack	Osteoporosis Medication	Venereal Disease
Connective Tissue Disease	Heart Disease	Pacemaker	Other
Cough	Heart Murmur	Radiation Treatment	

PLEASE TURN OVER

DENTAL HISTORY

Name of Previous Dentist and Location: __________________________________ Date of Last Exam: ____________________

What is your reason for coming to Ghareeb Dental Group: ____

How did you hear about us? ____

Have you had any trouble associated with any previous dental treatment? ____

What is your chief dental complaint? ____

How often do you brush your teeth? (circle one) **Never | Once a week | Few times a week | Once a day | Twice or more a day**

How often do you floss? (circle one) **Never | Once a week | Few times a week | Once a day | More than once a day**

What kind of toothpaste do you use? ______________________ What (if any) mouth rinse do you use? _____________________

Are your teeth sensitive to hot/cold/sweet/sour? **Y / N**

Do your gums bleed while brushing or flossing? **Y / N**

Do you feel pain in or around your teeth or gums? **Y / N** If so, please explain: ____

Do you have sores or lumps in or near your mouth? **Y / N**

Have you ever had any injuries involving your head, neck or jaw? **Y / N**

Have you ever had pain or clicking in your jaw? **Y / N**

Have you ever had difficulty in opening, closing, or chewing? **Y / N**

Do you have frequent headaches? **Y / N**

Have you had prolonged bleeding following an extraction? **Y / N** If so, please explain: _________________________________

Have you had difficult extractions in the past? **Y / N** If so, please explain: ____

Do you clench or grind your teeth? **Y / N** If so, how often? ____

Do you like your smile? **Y / N**

Is there anything you would like to change about your teeth or smile? ____

Additional Comments: ____

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I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form, and I understand the HIPPA regulatory laws.

Patient/Guardian Signature: ____ **Date:** __________________________