Fairfax Dental Esthetics
Dr. Sanae Berrada & Dr. Sandra Glikman
9621 Fairfax Blvd. Fairfax, VA 22031
P# 703-279-3400

Medical and Dental History

We ask the following medical and dental history questions to insure safe treatment. Please, indicate your response to each question with a check mark. If you are unsure of the answer, leave the blank. Keep us informed of any changes in your health.

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Yes	No		Yes	No	
		Are you in good health?			Cancer? **List**_____
		Do you take any medicine, pills, drugs?(**list**)			Any Tumor or Growth? (**circle one**)
		_____			Blood Disorder or AIDS? (**circle one**)
		_____			X-Ray treatments?
		_____			Glaucoma or eye trouble?
		Are currently under treatment by a physician? (**please explain**)_____			Do you wear contacts or glasses?
		_____			Trouble hearing?
					Nervous problems?
		Have you ever had an unusual reaction or are you allergic to any medication (Penicillin, Codeine, Novocain, Aspirin)? List_____			Mental illness?
					Do you smoke?
					Sexually transmitted disease? **List**_____
		_____			(Women) Are you pregnant?
		Are there any foods you do not eat? (**list**)			Are you on a diet?
		_____			
		A serious illness or major operation?			Do you exercise regularly?
		Trouble walking, sitting or lying down?			Are you bothered with tooth sensitivity? (cold, Pressure?) _____
		High Cholesterol?			
		Do you have high or low blood pressure?			Do you have any problems eating or swallowing?
		Any bleeding problem or on blood thinner?			Do your gums bleed when brushing or flossing?
		Anemia?			Have you ever had any injury to your face or jaw?
		Rheumatic Fever?			Do you grind or clench your teeth?
		Heart Murmur or Heart Valve Defect?			Does your jaw ever get “out-of-joint” clicks or pop?
		Heart Diseases?			Are you aware of any swelling, rushes, lumps, white patches in your mouth?
		Frequent Headaches?			
		Epilepsy?			Are you unhappy with your smile or teeth color?
		Circulation problems?			Do you have breath problems or mouth odors?
		Hepatitis, jaundice or liver disease? (**circle one**)			Do you fear dental treatment?
		Tuberculosis or lung disease? (**circle one**)			Have you ever had braces, orthodontics?
		Asthma, hay fever, sinus trouble?(**circle one**)			Root canal therapy?
		Stomach trouble , ulcers? (**circle one**)			Gum treatment?
		Kidney Disease?			Nitrous Oxide (laughing gas)?
		Diabetes?			Been put to sleep for dental treatment?
		Do you require medication prior dental treatment? (antibiotics)			Any unusual dental experience? (**please explain**)
		Thyroid Disease?			_____
					_____

Preferred Pharmacy_____ Phone_____

Please add additional information about your medical or dental health, past or present that might aid in your treatment _____