Welcome to Star Dentistry

Great Smile, Good Life

Please enter your Medical & Dental History

New Patient Medical History			
Last Name:			
First Name:		Date of Birth:	
Physician's Name:		City/State:	

List all medications you are currently taking	
Any other medications?	

Are you allergic to any of the following?					
Y	N		Y	N	
		Anesthetic			Iodine
		Aspirin			Latex
		Codeine			Penicillin
		Ibuprofen			Sulfite
Any other allergies?					

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimim, Adipex, Fastin (brand names of phentermine), Pondimim (fenfluramine) and Redux (dexfenfluramine)

	Yes		No

Pregnant?		Yes		No
Nursing?		Yes		No
Taking birth control pills?		Yes		No

Have you had any serious illness or operations? If yes, please describe.

	Yes		No

Have you ever had a blood transfusion? If yes, give approx. dates.

	Yes		No

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Do you have or have you had any of the following?					
Y	N		Y	N	
		Anemia			Hepatitis
		Arthritis, Rheumatism			Hernia Repair
		Artificial Heart Valves			High Blood Pressure
		Artificial Joints, Pins etc			HIV/AIDS
		Asthma			Jaw Pain
		Back Problems			Kidney Disease
		Bleeding Abnormally			Liver Disease
		Blood Disease			Mitral Valve Prolapse
		Cancer			Pacemaker
		Chemical Dependency			Radiation Treatment
		Chemotherapy			Respiratory Disease
		Circulatory Problems			Rheumatic Fever
		Congenital Heart Lesions			Scarlet Fever
		Cortisone Treatments			Shortness of Breath
		Cough, Persistent			Skin Rash
		Cough up Blood			Stroke
		Diabetes			Swelling of Feet or Ankles
		Epilepsy			Thyroid Problems
		Fainting			Tobacco Habit
		Glaucoma			Tonsillitis
		Headaches			Tuberculosis
		Heart Murmur			Ulcer
		Heart Problems			Venereal Disease
		Hemophilia			Sinus Problems
Any other issues?					

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New Patient Dental History					
Former Dentist			City/State		
Date of last dental care?			Date of last dental X-rays?		
How often do you floss?			How often do you brush?		
Y	N		Y	N	
		Bad Breath			Periodontal treatment
		Bleeding Gums			Sensitivity to cold
		Clicking or popping jaw			Sensitivity to hot
		Food collection between teeth			Sensitivity to sweets
		Grinding teeth			Sensitivity when biting
		Loose teeth or broken fillings			Sores or growths in your mouth
Any other issues?					

To the best of my knowledge, the above information is complete and correct.
I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Date`	(signature)