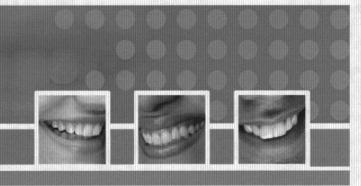
Shalom Dental

5801 Allentown Road Suite 307 Suitland MD 20746 (240)455-7842



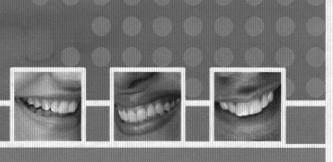
Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and i a way that watches out for your overall health and well-being. Would you consider yourself to be in fairly good health? Yes No Within the past year, have there been any changes in your general health? Yes No What is the date (or approximate date) of your last medical exam? Your Primary Care Physician's name, address, & phone number: Please mark any of the following to indicate Yes in response to the question: Have you ever had complications following dental treatment? Are you currently under the care of a physician due to a specific condition? Have you been hospitalized within the last 5 years due to a surgery or illness? Are you currently taking any prescription or non-prescription medications? Do you use tobacco (smoking or chewing)? Do you require the use of corrective lenses (contacts or glasses)? Do you have any other conditions, diseases, etc., not listed above that we should be aware of? If any of the previous questions are marked, please explain:	Patient Name:			
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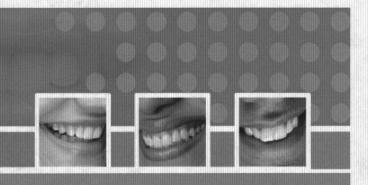
Suitland MD 20746 (240)455-7842



Please indicate if you have experienced any of the following: *Pre-Med - Amox	Yes, when is the due da	te?		
Allergy - Aspirin Allergy - Codeine Allergy - Erythro Allergy - Hay Fever Allergy - Latex Allergy - Other Allergy - Penicillin Allergy - Sulfa Arthritis Artificial Joints Asthma Blood Disease Cancer Diabetes Dizziness Epilepsy Excessive Bleeding Fainting Glaucoma Head Injuries Heart Disease Heart Murmur Hepatitis High Blood Pressure HIV Jaundice Kidney Disease Liver Disease Mental Disorders Nervous Disorders Other Pacemaker Pregnancy Radiation Treatment Respiratory Problems Stowach Problems Stroke Tuberculosis Tumors Ulcers				
Allergy - Aspirin	Please indicate if you have	e experienced any of the fo	ollowing:	
Allergy - Latex	*Pre-Med - Amox	*Pre-Med - Clind	*Pre-Med - Other	Allergies
Anemia Arthritis Artificial Joints Asthma Blood Disease Cancer Diabetes Dizziness Epilepsy Excessive Bleeding Fainting Glaucoma Head Injuries Heart Disease Heart Murmur Hepatitis High Blood Pressure HIV Jaundice Kidney Disease Liver Disease Mental Disorders Nervous Disorders Other Pacemaker Pregnancy Radiation Treatment Respiratory Problems Rheumatic Fever Rheumatism Sinus Problems Stomach Problems Stroke Tuberculosis Tumors Ulcers	Allergy - Aspirin	Allergy - Codeine	Allergy - Erythro	Allergy - Hay Fever
Blood Disease Cancer Diabetes Dizziness Epilepsy Excessive Bleeding Fainting Glaucoma Head Injuries Heart Disease Heart Murmur Hepatitis High Blood Pressure HIV Jaundice Kidney Disease Liver Disease Mental Disorders Nervous Disorders Other Pacemaker Pregnancy Radiation Treatment Respiratory Problems Rheumatic Fever Rheumatism Sinus Problems Stomach Problems Stroke Tuberculosis Tumors Ulcers	Allergy - Latex	Allergy - Other	Allergy - Penicillin	Allergy - Sulfa
Epilepsy Excessive Bleeding Fainting Glaucoma Head Injuries Heart Disease Heart Murmur Hepatitis High Blood Pressure HIV Jaundice Kidney Disease Liver Disease Mental Disorders Nervous Disorders Other Pacemaker Pregnancy Radiation Treatment Respiratory Problems Rheumatic Fever Rheumatism Sinus Problems Ulcers Stroke Tuberculosis Tumors Ulcers	Anemia	Arthritis	Artificial Joints	Asthma
Head Injuries	Blood Disease	Cancer	Diabetes	Dizziness
High Blood Pressure HIV Jaundice Kidney Disease Liver Disease Mental Disorders Nervous Disorders Other Pacemaker Pregnancy Radiation Treatment Respiratory Problems Rheumatic Fever Rheumatism Sinus Problems Stomach Problems Stroke Tuberculosis Tumors Ulcers	Epilepsy	Excessive Bleeding	Fainting	Glaucoma
Liver Disease	Head Injuries	Heart Disease	Heart Murmur	Hepatitis
Pacemaker Pregnancy Radiation Treatment Respiratory Problems Rheumatic Fever Rheumatism Sinus Problems Stomach Problems Stroke Tuberculosis Tumors Ulcers	High Blood Pressure	HIV	Jaundice	Kidney Disease
Rheumatic Fever Rheumatism Sinus Problems Stomach Problems Stroke Tuberculosis Tumors Ulcers	Liver Disease	Mental Disorders	Nervous Disorders	Other
Stroke Tuberculosis Tumors Ulcers	Pacemaker	Pregnancy	Radiation Treatment	Respiratory Problems
	Rheumatic Fever	Rheumatism	Sinus Problems	Stomach Problems
Venereal Disease Venereal Disease	Stroke	Tuberculosis	Tumors	Ulcers
	Venereal Disease	Venereal Disease		

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What is the reason for your dental visit today?				
When was your last visit to the dentist (if to a different office)?				
What was done on your last dental visit (if to a different office)?				
Prior Dentist's name, address, & phone number:				
How frequently do you brush your teeth?				
3 (+) a day Twice a day Once a day Weekly Seldom				
How frequently do you floss your teeth?				
1 (+) a day 2 - 6 weekly 1 - 6 monthly Seldom Never				
Please mark any of the following to indicate Yes in response to the question:				
Do your gums bleed when you brush or floss?				
Do your teeth experience sensitivity to cold or hot temperatures?				
Are any of your teeth currently causing you pain?				
Do you grind your teeth (either consciously or during sleep)?				
Are any of your teeth loose, or are you concerned about any teeth loosening?				
Do you currently have any dental implants, dentures, or partials?				
If any of the previous questions are marked, please explain:				
ii any or the previous questions are marked, please explain:				