NORMAN D. JACOBSKIND, DDS PC
PROFESSIONAL DENTAL SOLUTIONS

Adult Medical / Dental History

Medical History

Physician's name ______________ Town ______________ Last visit *(approximately)* __________

Please list any past serious illnesses or operations ______________ Date *(approximately)* __________

Have you ever had a blood transfusion? Y N If so, please list dates *(approximately)* ______________

(Women) Are you pregnant? Y N Due date __________ Nursing? Y N On birth control? Y N

Please indicate if you have/had:

	Y	N		Y	N		Y	N		Y	N
Anemia	☐	☐	Circulatory problems	☐	☐	High blood pressure	☐	☐	Scarlet fever	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	Immune disorders	☐	☐	Shortness of breath	☐	☐
Artificial Heart Valves	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Sinus trouble	☐	☐
Artificial Joints	☐	☐	Epilepsy	☐	☐	Kidney disease	☐	☐	Sickle cell anemia	☐	☐
Asthma	☐	☐	Fainting	☐	☐	Low blood pressure	☐	☐	Skin rash	☐	☐
Use an inhaler?	☐	☐	Glaucoma	☐	☐	Mitral valve prolapse	☐	☐	Slow-healing wounds	☐	☐
Date of last attack	____		Hay fever / sinusitis	☐	☐	Osteoporosis	☐	☐	Stroke	☐	☐
Bleeding abnormalities	☐	☐	Headaches	☐	☐	Osteopenia	☐	☐	Swelling of ankles	☐	☐
Blood clotting disorders	☐	☐	Heart murmur	☐	☐	Pacemaker	☐	☐	Thyroid problems	☐	☐
Cancer	☐	☐	Heart disease	☐	☐	Radiation therapy	☐	☐	Tonsillitis	☐	☐
Chemical dependency	☐	☐	Hepatitis	☐	☐	In the head/neck?	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Type(s)	____		Respiratory disease	☐	☐	Ulcers	☐	☐
Cough (persistent)	☐	☐	Herpes	☐	☐	Rheumatic fever	☐	☐	Venereal disease	☐	☐

Please list any medications you are taking: ______________

Please list medication allergies (i.e. penicillin): ______________

Do you smoke? Y N How often? __________ Do you drink alcohol? Y N How often? __________

Dental History

Reason for today's visit ______________

Former dentist ______________ When did you last see a dentist? ______________

Please indicate if you have/had:

	Y	N		Y	N		Y	N
Bad breath	☐	☐	Lip or cheek biting	☐	☐	Sensitivity	☐	☐
Blisters/sores on lips or mouth	☐	☐	Loose teeth	☐	☐	To hot	☐	☐
Burning tongue sensation	☐	☐	Mouth breathing	☐	☐	To cold	☐	☐
Chewing difficulties	☐	☐	Nitrous oxide	☐	☐	To sweets	☐	☐
Clenching or grinding teeth	☐	☐	Orthodontic treatment	☐	☐	When biting	☐	☐
Food often stuck between teeth	☐	☐	Pain in the head/neck/jaw	☐	☐	Swollen or bleeding gums	☐	☐
Growths or sores in your mouth	☐	☐	Periodontal treatment	☐	☐			

How often do you brush? ______________ How often do you floss? ______________

Have you ever had to take antibiotic premedication prior to receiving dental treatment? Y N

Have you ever had an allergic reaction to local anesthesia (i.e. Novocaine)? Y N If yes, explain ______________

Is there anything else in your medical/dental history not indicated on this form? ______________

The information I have provided on this page is accurate, to the best of my knowledge.

______________ Patient name (printed)   ______________ Signature (of parent/guardian, if under 18)   __________ Date

400 Merrifield Avenue
Oceanside, NY 11572

Phone: (516) 766-7400
Fax: (516) 766-0020