

Dustin Nelson, DDS

Total Smile Solutions

Health and Dental History

Have you been under the care of a medical doctor during the past two years? Yes No
If so for what? _____

Physician's Name _____ Phone # _____
Are you taking any medication now, including regular dosages of aspirin? Yes No

If so, please list name and dosage _____
Are you aware of having any allergic reaction to any medication or substance? Yes No
If so, please list _____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Concerns	Yes	No	Headaches	Yes	No	Have you had braces?	Yes	No
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No	Do you see a chiropractor?	Yes	No
Heart Murmur	Yes	No	Popping	Yes	No	Does floss shred when you use it?		
High Blood pressure	Yes	No	Limited opening	Yes	No		Yes	No
Mitral Valve Prolapse	Yes	No	Congested ears	Yes	No	Does food pack or catch between		
Artificial Heart Valve	Yes	No	Dizziness	Yes	No	teeth?	Yes	No
Pacemaker	Yes	No	ringing Ears	Yes	No			
Stroke	Yes	No	Loose Teeth	Yes	No	Do you smoke or chew tobacco?		
Asthma	Yes	No	Posture Problems	Yes	No		Yes	No
Liver disease/jaundice	Yes	No	Clenching	Yes	No	Do your gums bleed?	Yes	No
Latex Sensitivity	Yes	No	Grinding	Yes	No	Does your breath concern you?		
Artificial Joints	Yes	No	Facial Pain	Yes	No		Yes	No
Kidney Trouble	Yes	No	Sensitive Teeth	Yes	No			
Radiation/Chemotherapy	Yes	No	Neck Pain	Yes	No			
Epilepsy	Yes	No	Bell's Palsy	Yes	No			
Diabetes	Yes	No						
Hepatitis	Yes	No	Difficulty Swallowing	Yes	No			
AIDS/HIV	Yes	No	Difficulty Chewing	Yes	No			
Sickle Cell Disease	Yes	No	Trigeminal Neuralgia	Yes	No			
Neurological Disorder	Yes	No	Tingling in arms/fingers	Yes	No			
Psychiatric/Psychological	Yes	No	Insomnia/frequent waking	Yes	No			

Do you have or have you had any disease, condition or problem not listed? _____

Women: Are you: Pregnant? _____ Nursing? _____ Taking birth control pills? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Print Name _____

Address: _____

Signature _____ Date _____

Social Security Number _____ Date of Birth _____

E-mail address _____

PLEASE FAX THIS TO OUR OFFICE TODAY AT 626-577-1463, THANK YOU!

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