



# Dr. Joseph Sachs & Associates

|                        |                              |                             |
|------------------------|------------------------------|-----------------------------|
| Last Name _____        | First Name _____             | Date Of Birth _____         |
| Address _____          |                              | Home Telephone _____        |
| City _____             | State _____                  | Zip Code _____              |
| Employer _____         | Social Security Number _____ |                             |
| Business Address _____ |                              | Business Telephone _____    |
| City _____             | State _____                  | Zip Code _____              |
| Present Position _____ |                              | Referred By _____           |
| Physician _____        | Office Telephone _____       | Date Of Last Physical _____ |

## MEDICAL / DENTAL HISTORY

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1 Are you in good health now? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 Are you under any medical treatment now? -----  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Are you pregnant? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 Have you ever had a serious accident involving head injuries? -----                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 Have you had any major operations? -----  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 Have you had any adverse response to any drugs? -----                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 Has a physician ever informed you that you had: A Heart Ailment or Murmur? -----          | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 High Blood Pressure? -----  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 Respiratory Disease? -----  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 Diabetes? -----  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 Rheumatic Fever? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 Tumors or Growths? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 Any Blood Disease? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14 Any Liver Disease? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15 Any Kidney Disease? -----  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16 Any Stomach or Intestinal Disease? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17 Yellow Jaundice or Hepatitis? Year _____ -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18 Any Sexual Transmitted Disease? Year _____ -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19 AIDS, ARC or HIV? -----  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20 Do you have night sweats accompanied by weight loss or cough? -----                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 21 Are you on a diet for medical reasons at this time? -----                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 22 Are you now taking drugs or medications? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23 Are you allergic to any drugs or material resulting in hives, asthma, eczema, etc? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 24 Have any wounds healed slowly or presented any complications? -----                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 25 Do you have a history of fainting? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26 Have you ever had any X-RAY TREATMENT (other than diagnostic)? -----                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 27 Do You have pain in or near your ears? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 28 Do you have any unhealed areas or inflamed area in or around your mouth? -----           | <input type="checkbox"/> | <input type="checkbox"/> |
| 29 Have you experienced any growth or sore spots in your mouth? -----                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 30 Have you ever had local anesthetic? -----  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31 Any adverse reactions to local anesthetic? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32 Any difficult extractions in the past? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33 Prolonged bleeding following extractions in the past? -----                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 34 Do your gums bleed? -----  | <input type="checkbox"/> | <input type="checkbox"/> |
| 35 Have you ever had instructions on the correct method of brushing your teeth? -----       | <input type="checkbox"/> | <input type="checkbox"/> |
| 36 Have you ever had instructions on the care of your gums? -----                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 37 Do you chew only on one side of your mouth? If so Why? -----                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 38 Do you habitually clench your teeth during the night or day? -----                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 39 When was your last full mouth x-ray taken? -----   | <input type="checkbox"/> | <input type="checkbox"/> |
| 40 Are you having any dental complaints at his time? -----                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, location? _____  | <input type="checkbox"/> | <input type="checkbox"/> |

Signature \_\_\_\_\_

Reviewed Medical History with patient on: \_\_\_\_\_