White Oak Family Dentistry
Cosmetics & Implants

Robert J. Luszczak, D.D.S.

Dental & Medical History:

What is your main concern? ____

Have you ever had a serious problem in the past with dental work?	Y	N	Do you have any speech problems?	Y	N
Have you had orthodontic treatment?	Y	N	Do you still have your wisdom teeth?	Y	N
Have there been any injuries to your mouth/teeth/chin/face? Please circle	Y	N	Do you have any missing or extra teeth?	Y	N
Have you had any implants?	Y	N	Do you use more than 2 pillows to sleep?	Y	N
Have you gained or lost more than 10 lbs. in the past year?	Y	N			

If you require antibiotics prior to dental work, please list name and dosage ____

Please list all prescription and over the counter drugs that you are currently taking: ____

Are you happy with your smile? Y N If not, what would you change? ____

Have you ever taken any diet pills, such as Phen-Fen (AKA Redux or Pondimin)? Y N If so, when? ____

Do you have a personal physician? Y N Name:____________________Phone #:____________________Date of last visit:________________

Are you currently under the care of a physician? Y N If yes, please explain:____

Please describe your current dental health: Good Fair Poor Please describe your current physical health: Good Fair Poor

For Women: Are you taking birth control? Y N Are you pregnant? Y N # of weeks:_______ Are you nursing? Y N

Have You Ever Had Any of the following diseases or medical problems?

Abnormal Bleeding	Y	N	Difficulty Breathing	Y	N	Neurological Disorders	Y	N
Alcohol or Drug Abuse	Y	N	Emphysema	Y	N	Nervous/Anxious	Y	N
Allergies/Hives	Y	N	Epilepsy or Seizures	Y	N	Pacemaker	Y	N
Anemia	Y	N	Fainting Spells or Dizzy	Y	N	Psychiatric Problems	Y	N
Arthritis	Y	N	Frequent Headaches	Y	N	Psychological Care	Y	N
Artificial Bones/Joints/Valves	Y	N	Glaucoma	Y	N	Radiation Treatment	Y	N
Asthma	Y	N	Hay Fever or Scarlet Fever	Y	N	Rheumatic Fever	Y	N
Blood Transfusion	Y	N	Heart Attack/Surgery/Disease	Y	N	Shingles	Y	N
Bruise Easily	Y	N	Heart Murmur	Y	N	Sickle Cell Disease	Y	N
Cancer: Type _____________	Y	N	Hemophilia	Y	N	Sinus Problems	Y	N
Chemotherapy	Y	N	Hepatitis: Type______	Y	N	Stroke	Y	N
Chronic Cough	Y	N	Herpes/Cold Sores/Fever Blisters	Y	N	Surgery: For What?________	Y	N
Congenital Heart Defect	Y	N	High Blood Pressure	Y	N	Swollen Ankles	Y	N
Cortisone Medicine	Y	N	HIV	Y	N	Thyroid Problems	Y	N
Diabetes	Y	N	Kidney Problems	Y	N	Tuberculosis (TB)	Y	N
Diet (Special/Restricted)	Y	N	Liver Disease	Y	N	Tumors	Y	N
Low Blood Pressure	Y	N	Lupus	Y	N	Ulcers	Y	N
Mitral Valve Prolapse	Y	N	Venereal Disease	Y	N	Yellow Jaundice	Y	N

Do you have or have you had any disease, problem or condition not listed? Y N If yes, please list: ____

Are you allergic to any of the following?

Aspirin Y N Dental Anesthetics Y N Latex Y N Penicillin Y N Codeine Y N Erythromycin Y N Tetracycline Y N

Please list any other drugs or materials you are allergic to:____

I understand that all the information that I have given today is correct to the best of my knowledge and that the above information is necessary to provide me with dental care in a safe and efficient manner. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical or dental status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Patient/Guardian Signature ____Date ____________________

History Review

Dentist Signature ____Date ____________________