RAMSIN K. DAVOUD DDS

FAMILY & COSMETIC DENTISTRY

Ramsin k. Davoud DDS. Family & Cosmetic Dentistry
1840 N Olive Ave Ste #2, Turlock, CA 95382
Phone: (209) 690-8051

Patient Name : ____ Birthday: _____/_____/________

DENTAL HISTORY

1. When was your last dental visit?
____
2. Where and who was your last dentist?
____
3. Approximately how often were your appointments with your last dentist?
____
4. Are you experiencing any dental problems? (Please explain):
____
5. How often do you: Brush your teeth? ______________ Floss? ______________ Water Jet Floss? ______________
6. Do you have any: Loose Teeth? ☐ Yes ☐ No Chipped Teeth? ☐ Yes ☐ No Broken Teeth? ☐ Yes ☐ No
7. Are there any spaces between your teeth where food often gets stuck? ☐ Yes ☐ No
8. Do you frequently get headaches or migraines? ☐ Yes ☐ No
9. Do you have any jaw joint issues (such as popping) or pain? ☐ Yes ☐ No
10. Do you clench and/or grind your teeth when you are awake or asleep? ☐ Yes ☐ No
11. Do your teeth feel worn down? ☐ Yes ☐ No
12. Do you snore at night or commonly have a hard time sleeping well? ☐ Yes ☐ No
13. Do you have any sort of sleep apnea that you are aware of? ☐ Yes ☐ No
14. Have you ever had periodontal (gum) treatment of any kind? ☐ Yes ☐ No
15. Do your gums bleed when you brush your teeth? ☐ Yes ☐ No
    Do your gums bleed when you floss? ☐ Yes ☐ No
16. Have you ever had orthodontic treatment such as braces or aligner therapy? ☐ Yes ☐ No
17. Are you interested in short-term braces? ☐ Yes ☐ No
18. Do you have wisdom teeth? ☐ Yes ☐ No *If so, are they bothering you?* ☐ *Yes* ☐ *No*
19. Are you interested in dental implants to replace missing teeth? ☐ Yes ☐ No
20. What level of dental treatment are you interested in (circle one): ☐ Emergency ☐ Long-term
21. How do you feel about your smile? What (if any) improvements would you like to see?
____
22. What are your goals with our office?
____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

MEDICAL HISTORY

Are you under a physician's care now? ☐ Yes ☐ No

If Yes, Please Explain: ____________________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If Yes, Please Explain: ____________________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

If Yes, Please Explain: ____________________

Are you taking any medications, pills or drugs? ☐ Yes ☐ No

If Yes, Please Explain: ____________________

Do you take or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

If Yes, Please Explain: ____________________

Have you ever taken Fosamax, Boriva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

If Yes, Please Explain: ____________________

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are You -

Pregnant/Trying to get pregnant? ☐ Yes ☐ No

Taking oral contraceptives? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics

☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other

If Other, Please Explain: ____________________

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Aizheimer's Disease	☐ Anaphylaxis	☐ Anemia
☐ Angina	☐ Arthritis/Gout	☐ Artificial Heart Valve	☐ Artificial Joint
☐ Asthma	☐ Blood Disease	☐ Blood Transfusion	☐ Breathing Problem
☐ Bruise Easily	☐ Cancer	☐ Chemotharapy	☐ Chest Pains
☐ Cold Sores/Fever Blisters	☐ Congenital Heart Disorder	☐ Convulsions	☐ Cortisone Medicine
☐ Diabetes	☐ Drug Addiction	☐ Easily Winded	☐ Emphysema
☐ Epilepsy or Seizures	☐ Excessive Bleeding	☐ Excessive Thirst	☐ Fainting Spells/Dizziness
☐ Frequent Cough	☐ Frequent Diarrhea	☐ Frequent Headaches	☐ Genital Herpes
☐ Glaucoma	☐ Hay Fever	☐ Heart Attack/Failure	☐ Heart Murmur
☐ Heart Pacemaker	☐ Heart Trouble/Disease	☐ Hemophilia	☐ Hepatitis A
☐ Hepatitis B or C	☐ Herpas	☐ High Blood Pressure	☐ High Cholesterol
☐ Hives or Rash	☐ Hypoglycemie	☐ Irregulare Heartbeat	☐ Kidney Problems
☐ Leukemia	☐ Liver Disease	☐ Low Blood Pressure	☐ Lung Disease
☐ Mitral Valve Prolapse	☐ Osteoporosis	☐ Pain in Jaw Joints	☐ Parathyroid Disease
☐ Psychiatric Care	☐ Radiation Treatments	☐ Recent Weight Loss	☐ Renal Dialysis
☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever	☐ Shingles
☐ Sickle Cell Disease	☐ Sinus Trouble	☐ Spina Bifida	☐ Stomach/Intestinal Disease
☐ Stroke	☐ Swelling of Limbs	☐ Thyroid Disease	☐ Tonsilitis
☐ Tuberculosis	☐ Tumors or Growths	☐ Ulcers	☐ Venereal Disease
☐ Yellow Jaundice			

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If Yes, Please List: ______________________________

Comments : ______________________________

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☐ To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient / Parent (if minor) Signature: ______________________ Date: __________