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*Welcome. So that we may provide you with the best possible care please complete the medical /dental history form.  
 All information is completely confidential.*

**HEALTH & DENTAL HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of last health care exam: \_\_\_\_\_ What was this exam for? \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_ Name of previous dentist: \_\_\_\_\_

Have you been hospitalized in the last 5 years? (Please circle) No      Yes

If yes, reason: \_\_\_\_\_

Are you currently receiving care? No      Yes If yes, nature of care: \_\_\_\_\_

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

Anemia or Blood Disorder	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease	No	Yes	Joint Replacement When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Venereal Disease	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Other Conditions	No	Yes
Heart Stent When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment	No	Yes	Tagamet <sup>®</sup> (cimetidine) or Prilosec <sup>®</sup> (omeprazole)	No	Yes
Antacids	No	Yes	Cardizem <sup>®</sup> (diltiazem) or Calan, Isoptin <sup>®</sup> (Verapamil)	No	Yes
Dilantin <sup>®</sup> or Tegretol <sup>®</sup>	No	Yes	Serzone <sup>®</sup> (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan <sup>®</sup> (fluconazole) or Sporonox <sup>®</sup> (itraconazole)	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Biaxin <sup>®</sup> (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate (bone) drugs (Fosamax <sup>®</sup> , Aredia <sup>®</sup> , Zometa <sup>®</sup> , Actonel <sup>®</sup> , Boniva <sup>®</sup> ) If so, when did the treatment begin? _____				No	Yes
When did the treatment end? _____					
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Do you have sensitivity to hot or cold?	No	Yes	History of orthodontic treatment?	No	Yes
Do you have sensitivity to sweets?	No	Yes	History of oral surgery?	No	Yes
Pain while biting or chewing?	No	Yes	Periodontal surgery?	No	Yes
Have you noticed any mouth odors or bad tastes?	No	Yes	Have you ever had your teeth ground or bite adjusted?	No	Yes
Do you frequently get cold sores, blisters or any other oral lesions?	No	Yes	Have you ever worn a bite plate or mouth guard?	No	Yes
Do your gums bleed or hurt?	No	Yes	Have you ever had serious injury to your mouth or head?	No	Yes
Have your parents experienced gum disease or tooth loss?	No	Yes	Have you ever had clicking or popping of the jaw?	No	Yes
Have you noticed any loose teeth or change in your bite?	No	Yes	Have you ever had pain in the jaw ears or side of face?	No	Yes
Does food tend to get caught between your teeth. If yes, where?	No	Yes	Have you ever had difficulty on opening or closing your mouth?	No	Yes
Do you clench or grind your teeth while awake or asleep?	No	Yes	Have you ever had neck-aches, headaches or shoulder aches?	No	Yes
Do you have tired jaws, especially in the morning?	No	Yes	Would you like to keep your teeth all your life?	No	Yes
Do you smoke/ chew tobacco?	No	Yes	Do you feel nervous about having dental treatment?	No	Yes
Do you mouth breathe while awake or asleep?	No	Yes	What is your biggest concern about dental treatment?_____		

Women: Are you pregnant? No    Yes  
 If no, are you planning a pregnancy in the near future? No    Yes  
 Are you a nursing mother? No    Yes  
 Are you taking birth control pills? No    Yes

Abnormal Blood Pressure? (Please circle) No    Yes  
 Have you ever received a diagnosis of "high blood pressure"? No    Yes  
 What is your normal blood pressure? \_\_\_\_\_

Have you had an allergic reaction to:

a. Local anesthetics .....	No	Yes
b. Penicillin or other antibiotics .....	No	Yes
c. Aspirin, Ibuprofen or Tylenol .....	No	Yes
d. Codeine, Valium® or other sedatives.....	No	Yes
e. Latex or Metals		
f. Other (please specify)_____		

Is there anything else about you that you would like us to know? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

*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 or agency, who may release such information to you. I will notify the doctor of change in my health and medication.*

\_\_\_\_\_  
 Patient (Print Name) Patient Signature Date