Nilay Nanavati, DDS (631) 226-4540

Medical History

Name: Last_____ First_____ Date:_____

Email : _____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being .

Would you consider yourself to be in good health? ○ Yes ○ No

Within the past year , have there been any changes in your general health? ○ Yes ○ No
What is the date (or approximate date) of your last medical exam? _____

Are you under the care of a physician due to a specific condition? ○ Yes ○ No
If "yes" please describe briefly: _____

Your Primary Care Physician
number?_____
Your Specialist's name and phone number (if applicable)?
_____

Have you been hospitalized within the last 5 years due to a surgery or illness? ○ Yes○ N

If "yes" please describe briefly:_____

Do you use tobacco (smoking or chewing)? ○ Yes ○ No

Are you currently taking any prescription or non-prescription medications? ○ Yes ○ No

If "yes" please list all medications in the appropriate areas:

Heart Problems (high blood pressure, cholesterol, blood thinners, water pills etc):_____

_____

_____

Diabetes Medications (insulin etc):_____

Anti-anxiety medications:_____

Other prescription medications:_____

_____

Over-the-counter medications (including vitamins and herbal remedies):_____

_____

WOMEN ONLY: Are you on birth control? ○ Yes ○ No
Are you pregnant? ○ Yes ○ No Due Date?_____

OVER

Please check any of the following conditions that apply to your health

O Allergy - Latex	O Fainting	O Pregnancy
O Allergy - Other	O Glaucoma	O Radiation Treatment
O Allergy - penicillin	O Head Injury	O Respiratory Problems
O Anemia	O Heart Disease	O Rhumatic Fever
O Arthritis	O Heart Murmur	O Rheumatism
O Artificial Joints	O High Blood Pressure	O Sinus Problems
O Asthma	O Hepatitis	O Stomach Problems
O Blood Disease	O HIV	O Stroke
O Cancer	O Jaundice	O Tuberculosis
O Coumadin	O Kidney Disease	O Tumors
O Asperin/Plavix	O Liver Disease	O Ulcers
O Diabetes	O Mental Disorders	O Venereal Disease
O Dizziness	O Mitral Valve Prolapse	
O Epilepsy	O Nervous Disorders	
O Excessive Bleeding	O Pacemaker	

Do you have any other health issues or allergies? Please describe:_____
What is the reason for your dental visit today?_____

When was your last visit to the dentist?_____
What was done at your last visit?_____

Prior dentist's name, address, & phone:_____
How often do you brush? ○ **3(+) a day** ○ **Twice a day** ○ **Once a day** ○ **Weekly** ○ **Seldom**

Type of brush used: ○ **Hard** ○ **Medium** ○ **Soft** ○ **Electric** ○ **Water Plc**

How often do you floss? ○ **1 (+) a day** ○ **2-6 weekly** ○ **1-6 monthly** ○ **Seldom** ○ **Never**

Do your gums bleed when you brush? ○**Yes** ○ **No**

Do your teeth experience sensitivity to heat or cold? ○ **Yes** ○ **No**

Are any of your teeth currently causing you pain? ○ **Yes** ○ **No**

Do you grind your teeth (either consciously or during sleep)? ○ **Yes** ○ **No**

Are any or your teeth loose? ○ **Yes** ○ **No**

Do you currently have any implants? ○**Yes** ○**No, dentures?** ○**Yes** ○ **No, partials?** ○ **Yes** ○ **No**

Are you having or have you ever experienced jaw pain (TMJ pain)? ○**Yes** ○**No** **Please describe:**

_____I

understand that the information that I have given today is correct to the best of my Knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed concent that I may need during diagnosis and treatment.

Pharmacy Name & Address : _____

SIGNATURE:_____