

# MARTIN A. HIRSCH, DMD

Art + Science for your teeth

2800 North Sheridan Road ♦ Suite 204 ♦ Chicago ♦ 60657 ♦ 773.248.6140 ♦ 773.248.4628 Fax  
www.martinahirschdds.com ♦ drmartinhirsch@gmail.com

Today's Date: \_\_\_\_\_

DENTAL/MEDICAL HISTORY				
PATIENT NAME: LAST		FIRST	MIDDLE	DATE OF BIRTH
RESIDENCE ADDRESS: NUMBER/STREET		CITY	STATE	ZIP CODE
HOME PHONE	BUSINESS PHONE		PHYSICIAN'S NAME	PHYSICIAN'S PHONE

Please check Yes or No

- Y  N  Do you have pain in or near your ears?
- Y  N  Do you have any unhealed injuries or inflamed areas in or around your mouth?
- Y  N  Have you experienced any growths or sore spots in your mouth?
- Y  N  Does any part of your mouth hurt when clenching?
- Y  N  Have you ever had Novocaine or other dental anesthetic?
- Y  N  Have you ever had any reactions and/or allergic symptoms to Novocaine or anesthetics?
- Y  N  Have you ever had any difficult extractions in the past?
- Y  N  Have you ever had prolonged bleeding following extractions in the past?
- Y  N  Have you ever had Trench Mouth?
- Y  N  Do your gums bleed when you brush or eat?
- Y  N  Have you been instructed on the correct method of brushing teeth?
- Y  N  Have you been instructed on correct gum care?
- Y  N  Do you chew only on 1 side of your mouth?
- Y  N  Do you habitually clench or grind your teeth during the day or night?
- Y  N  Is any part of your mouth sore to pressure or irritants (cold, sweet, etc.)?

When was the last series of dental x-rays taken? \_\_\_\_\_

⇒ Where? \_\_\_\_\_

Do you have any current cosmetic concerns? \_\_\_\_\_

\_\_\_\_\_

Do you have any dental concerns or complaints you wish to discuss? \_\_\_\_\_

\_\_\_\_\_

Are you under medical treatment currently? Please name: \_\_\_\_\_

\_\_\_\_\_

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Y  N  Have you had any major surgery?

⇒ If so, please list \_\_\_\_\_

Y  N  Have you had a serious accident involving head injuries?

Are you allergic to or had any negative responses to the following:

Y  N  Penicillin, Mycins or other antibiotics?

Y  N  Aspirin, Tylenol, Codeine or other type of pain/headache medication?

Y  N  Any other drug or medication?

Y  N  Any foods or cosmetics?

Y  N  Are you taking any medications currently?

⇒ If so, please list \_\_\_\_\_

Y  N  Have any wounds and/or cuts healed slowly?

Y  N  Do you have a history of fainting?

Y  N  Are you pregnant?

Have you had any of the following illnesses:

Y  N  Rheumatic Fever

Y  N  Bone or Joint disease

Y  N  Syphilis, Gonorrhoea or other Venereal Disease

Y  N  Jaundice

Y  N  High Blood Pressure

Y  N  AIDS

Y  N  Asthma

Y  N  Respiratory Disease

Y  N  Neuritis or Neuralgia

Y  N  Hepatitis

Y  N  Low Blood Pressure

Y  N  Blood Transfusions

Y  N  Liver Disease

Y  N  Heart Disease

Y  N  Pneumonia

Y  N  Nephritis (Kidney)

Y  N  Rectal Disease

Y  N  Bowel Disease

Y  N  Tumors or Growths

Y  N  Frequent Infections

Y  N  Arthritis

Y  N  Anemia

Y  N  Diabetes

Y  N  Cancer

Y  N  Epilepsy

Y  N  Allergies

Y  N  Smoking

Y  N  Have you ever had heart surgery or been told you have a heart valve problem?

Y  N  Do you have any missing or replaced body parts (heart valves, kidney, hip or joints)?

⇒ If so, please list \_\_\_\_\_

Y  N  Are you in general good health at this time?