ghareebdentalgroup.com

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KANAWHA CITY
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Dr. Sami Ghareeb Dr. Azita Misaghi Dr. Steven Ghareeb Dr. Mitri Ghareeb Dr. Matthew Scarberry Dr. Kayla Buchanan
Dr. Joshua Massey Dr. Carson Henley Dr. Lon Spain Dr. Alyssa Tenney Dr. Miranda Ferrari

HEALTH HISTORY

Patient Name: _____Today's Date: _____

In Case of Emergency, Please Contact: _____

Relationship to Patient: _____ Emergency Phone Number: _____

Physician Name: _____ Physician's Phone Number: _____

Date of last exam? _____ Are you currently under medical treatment? **Y / N** If so, for what? _____

Have you been hospitalized within the last 5 years? **Y / N** If so, for what reason? _____

Have you had joint replacement surgery? **Y / N** If so, what kind and when? _____

Have you had heart surgery? **Y / N** If so, what kind and when? _____

Have you previously been diagnosed with bacterial endocarditis? **Y / N** If so, when? _____

Have you previously been diagnosed with ulcerative colitis? **Y / N** If so, when? _____

Have you been advised by a doctor to take antibiotics prior to dental treatment? **Y / N** If so, for what? _____

Are you a diabetic? **Y / N** If so, last blood sugar reading? _____ When? _____ Last HbA1c? _____

Do you use tobacco? **Y / N** If so, what kind of tobacco do you use/how many packs a day? _____

Do you drink alcohol? **Y / N** If so, how many drinks a day? _____

Do you use controlled substances? **Y / N** Do you use recreational drugs? **Y / N**

Are you pregnant or think you may be pregnant? **Y / N** Are you currently on birth control? **Y / N** Are you nursing? **Y / N**

Are you allergic to any medications? **Y / N** If so, which ones? _____

Are you currently taking blood thinners (aspirin, warfarin, etc.)? **Y / N** If so, which one and frequency? _____

Please list all other allergies: _____

Please include a list of **ALL** medications: _____

_____

Do you have or have you had any of the following? Please circle.

Alzheimer's
Anemia
Arthritis
Artificial Joints
Artificial Heart Valve
Asthma/Bronchitis
Blood Disease
Bronchitis
Cancer/Chemotherapy
Chest Pain
Cough
Depression
Diabetes
Diarrhea
Dizziness/Fainting
Eating Disorder
Emphysema
Epilepsy
Excessive Bleeding
Fibromyalgia
Glaucoma
Growths
Head Injuries
Heart Attack
Heart Disease
Heart Murmur
Hepatitis
High Blood Pressure
HIV/AIDS
Hypoglycemia
Immune Suppression
Kidney Disease
Latex Rubber Allergy
Liver Disease
Low Blood Pressure
Mental/Nervous Disorders
Mitral Valve Prolapse
Osteoporosis
Pacemaker
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Shortness of Breath
Sinus Problems
Stomach Problems
Stroke
Swollen Ankles
Thyroid Problems
Tuberculosis
Tumors
Ulcers
Venereal Disease
Other

PLEASE TURN OVER

DENTAL HISTORY

Name of Previous Dentist and Location: _____ Date of Last Exam: _____

What is your reason for coming to Ghareeb Dental Group: _____

How did you hear about us? _____

Have you had any trouble associated with any previous dental treatment? _____

What is your chief dental complaint? _____

How often do you brush your teeth? (circle one) **Never | Once a week | Few times a week | Once a day | Twice or more a day**

How often do you floss? (circle one) **Never | Once a week | Few times a week | Once a day | More than once a day**

What kind of toothpaste do you use? _____ What (if any) mouth rinse do you use? _____

Are your teeth sensitive to hot/cold/sweet/sour? **Y / N**

Do your gums bleed while brushing or flossing? **Y / N**

Do you feel pain in or around your teeth or gums? **Y / N** If so, please explain: _____

Do you have sores or lumps in or near your mouth? **Y / N**

Have you ever had any injuries involving your head, neck or jaw? **Y / N**

Have you ever had pain or clicking in your jaw? **Y / N**

Have you ever had difficulty in opening, closing, or chewing? **Y / N**

Do you have frequent headaches? **Y / N**

Have you had prolonged bleeding following an extraction? **Y / N** If so, please explain: _____

Have you had difficult extractions in the past? **Y / N** If so, please explain: _____

Do you clench or grind your teeth? **Y / N** If so, how often? _____

Do you like your smile? **Y / N**

Is there anything you would like to change about your teeth or smile? _____

Additional Comments: _____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form, and I understand the HIPPA regulatory laws.

Patient/Guardian Signature: _____ Date: _____