JOSEPH. P. NORE DDS

Name _____ **Date of Birth** ____ _ /_____/_____

Contact in case of emergency _____ **telephone ( ) ____ -_____**

1. Are you under a physicians care now? ○Yes ○ No If yes, please explain: _____

Name of Physician _____ **Phone Number ( ) -**

2. Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain:

_____

3. Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____

4. Are you taking any medications, pills, or drugs? ○Yes ○ No If yes, please list: _____

_____

5. Do you smoke or chew tobacco? ○ Yes ○ No If yes, how many a day? _____ For how long? _____

6. Do you use controlled substances? ○ Yes ○ No

7. Do you have a history of alcohol or drug abuse? ○Yes ○ No

8. If yes, have you been in a rehabilitation program? ○Yes ○ No ○ N/A

Women only:

10. Are you pregnant? ○ Yes ○ No 11. Taking oral contraceptives? ○ Yes ○ No 12. Nursing? ○ Yes ○No

Are you allergic to any of the following?

14. □ Aspirin 15. □ Penicillin 16. □ Codeine 17. □ Acrylic 18. □ Metal 19. □ Latex

20 □ Other _____

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

22	*Artificial heart valve*	□**Yes**	□ **No**	**39**	*Anemia*	□**Yes**	□ **No**	**56**	*Chronic Pain*	□**Yes**	□ **No**
23	*Previous infective endocarditis*	□**Yes**	□ **No**	**40**	*Hemophilia*	□**Yes**	□ **No**	**57**	*Diabetes Tipo I or II*	□**Yes**	□ **No**
24	*Damaged heart valves*	□**Yes**	□ **No**	**41**	*Blood transfusion*	□**Yes**	□ **No**	**58**	*Severe weight loss*	□**Yes**	□ **No**
25	*Congenital Heart Disease*	□**Yes**	□ **No**	**42**	*Sicke cell anemia*	□**Yes**	□ **No**	**59**	*Gastrointestinal disease*	□**Yes**	□ **No**
26	*Cardiovascular disease*	□**Yes**	□ **No**	**43**	*AIDS or VIH infection*	□**Yes**	□ **No**	**60**	*Thyroid problems*	□**Yes**	□ **No**
27	*Heart attack*	□**Yes**	□ **No**	**44**	*Autoimmune disease*	□**Yes**	□ **No**	**61**	*Parathyroid disease*	□**Yes**	□ **No**
28	*Heart murmur*	□**Yes**	□ **No**	**45**	*Rheumatoid arthritis*	□**Yes**	□ **No**	**62**	*Hepatitis*	□**Yes**	□ **No**
29	*Mitral valve prolapse*	□**Yes**	□ **No**	**46**	*Systemic lupus*	□**Yes**	□ **No**	**63**	*Renal dyalisis*	□**Yes**	□ **No**
30	*Pacemaker*	□**Yes**	□ **No**	**47**	*Arthritis*	□**Yes**	□ **No**	**64**	*Stroke*	□**Yes**	□ **No**
31	*Cardiac arrythmia*	□**Yes**	□ **No**	**48**	*Osteoporosis*	□**Yes**	□ **No**	**65**	*Epilepsy*	□**Yes**	□ **No**
32	*Angina*	□**Yes**	□ **No**	**49**	*Joint replacement*	□**Yes**	□ **No**	**66**	*Psychiatric care*	□**Yes**	□ **No**
33	*Congestive heart failure*	□**Yes**	□ **No**	**50**	*Asthma*	□**Yes**	□ **No**	**67**	*Neurological disorders*	□**Yes**	□ **No**
34	*Arteriosclerosis*	□**Yes**	□ **No**	**51**	*Bronchitis*	□**Yes**	□ **No**	**68**	*Glaucoma*	□**Yes**	□ **No**
35	*High blood pressure*	□**Yes**	□ **No**	**52**	*Emphysema*	□**Yes**	□ **No**	**69**	*Kidney Problems*	□**Yes**	□ **No**
36	*Low blood pressure*	□**Yes**	□ **No**	**53**	*Sinus trouble*	□**Yes**	□ **No**	**70**	*Herpes*	□**Yes**	□ **No**
37	*Rheumatic fever*	□**Yes**	□ **No**	**54**	*Tuberculosis*	□**Yes**	□ **No**	**71**	*Organ transplant*	□**Yes**	□ **No**
38	*Abnormal bleeding*	□**Yes**	□ **No**	**55**	*Cancer/Chemotherapy*	□**Yes**	□ **No**	**72**	*Other:_____*	□**Yes**	□ **No**

DENTAL INFORMATION

	Yes	**No**
74. Do your gums bleed when you brush or floss?	□	□
75. Are your teeth sensitive to cold, hot, sweets or pressure?	□	□
76. Is your mouth dry?	□	□
77. Have you had any periodontal (gum) treatment?	□	□
78. Have you ever had orthodontic (braces) treatment?	□	□
79. Have you had any problems with previous dental treatment?	□	□
80. Are you currently experiencing dental pain or discomfort?	□	□
81. Do you have earaches or neck pain?	□	□
82.Do you have any clicking, popping or discomfort in the jaw?	□	□
83.Do you brux or grind your teeth?	□	□
84.Do you have sores or ulcers in your mouth?	□	□
85. Do you wear dentures or partials?	□	□

I authorize Joseph P. Nore DDS & Associates to perform the necessary dental services I (or the patient) may need. I also understand that providing incomplete/incorrect information may be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

PLEASE RETURN COMPLETED MEDICAL HISTORY AT FRONT DESK FOR SIGNATURE, THANK YOU

Date:_____ Signature Patient o Guardian._____ Dr. Signature. _____