Functional Aesthetic Dentistry
Designing Smiles, Enhancing Health
David T. Kiger D.D.S.

Health and Dental History

Have you been under the care of a medical doctor during the past two years? YES NO
If so, for what ____
Physician's Name _____________________________________Phone #. ___________________________
Are you taking any medication now, including regular dosages of aspirin YES NO
If so, please list name and dosage ____
Are you aware of having an allergic reaction to any medication or substance? YES NO
If so, please list____

Indicate which of the following you have had, or have at present, Circle "yes" or "no" to each item

Heart Concerns	Yes	No	Headaches	Yes	No
Congenital Heart Disease	Yes	No	Jaw Pain	Yes	No
Heart Murmur	Yes	No	Jaw Popping	Yes	No
High blood pressure	Yes	No	Limited opening	Yes	No
Mitral Valve Prolapse	Yes	No	Congested ears	Yes	No
Artificial Heart Valve	Yes	No	Dizziness	Yes	No
Pacemaker	Yes	No	Ringing ears	Yes	No
Stroke	Yes	No	Loose Teeth	Yes	No
Asthma	Yes	No	Posture Problems	Yes	No
Liver disease/jaundice	Yes	No	Clenching	Yes	No
Latex Sensitivity	Yes	No	Grinding	Yes	No
Artificial joints	Yes	No	Facial Pain	Yes	No
Kidney trouble	Yes	No	Sensitive Teeth	Yes	No
Radiation/Chemotherapy	Yes	No	Neck Pain	Yes	No
Epilepsy/seizures	Yes	No	Bell's Palsy	Yes	No
Diabetes	Yes	No			
Hepatitis	Yes	No	Difficulty Swallowing	Yes	No
AIDS/HIV	Yes	No	Difficulty Chewing	Yes	No
Sickle Cell Disease	Yes	No	Trigeminal Neuralgia	Yes	No
Neurological Disorders	Yes	No	Tingling in arms/fingers	Yes	No
Psychiatric/Psychological	Yes	No	Insomnia/frequent waking	Yes	No

Have you had braces	Yes	No
Do you see a chiropractor	Yes	No
Does floss shred when you use it?	Yes	No
Does food pack or catch between your teeth	Yes	No
Do you smoke or chew tobacco?	Yes	No
Do your gums bleed?	Yes	No
Does your breath concern you?	Yes	No

Do you have or have you had any disease, condition or problem not listed?____

Women: Are you: Pregnant?__________ Nursing?__________ Taking birth control pills?__________

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

Name ____ Date ____________________
Address ____________________________ City ___________________ State _____ Zip _______
Phone Number _______________________ Date of Birth _______________ Martial Status ______
Spouse's Name ____
Your Employer ____
Person Financially Responsible for this Account? ____

Were You Referred to us? If so by who? ____

For more information, please visit our website at www.davidkigerdds.com