GASSER DENTAL
DENTAL IMPLANTS

GASSER DENTAL CORPORATION
PATIENT MEDICAL HISTORY

Gasser Dental Corporation
17220 N. Boswell Blvd Suite 200W
Sun City, AZ 85373
623-972-8217
www.DrGasser.com
jlittle@drgasser.com

Email:_____ Date:_____
Name: _____ SSN:_____
Address: _____
City:_____State:_____ Zip: _____
Phone (Home):_____Alternate Number: _____
Date of Birth:_____Age:_____Sex: M F
How were you referred to this office? _____
Next of Kin:_____Phone: _____
Name of Physician:_____Phone: _____
Address: _____
Date of last physical exam?_____Reason: _____
Results: _____
Have you ever had radiation therapy? Yes No **IF** yes reason: _____
Date last dental x-rays taken:_____ Present oral problem: _____
Medication(s) you are currently taking: _____
Herbs and/or Supplements you are currently taking: _____
Do you take antibiotic pre-med before dental work? _____

Yes	No	Please check appropriate box / circle appropriate answer	Comments	STAFF ONLY
		CARDIOVASCULAR SYSTEM		
☐	☐	Heart trouble or heart murmur, pacemaker, defibrillator		
☐	☐	Pain or pressure in your chest, Shortness of breath		
☐	☐	Rheumatic Fever/Rheumatic heart disease		
☐	☐	Congestive Heart Disease		
☐	☐	Swollen or painful joints		Local
☐	☐	High or Low blood pressure		
☐	☐	Heart disease from childhood		
☐	☐	Arteriosclerosis (hardening of the arteries)		
☐	☐	Stroke or associated problems		
☐	☐	Artificial Heart Valve or Aortic Stenosis, Vascular Graft		
		GASTRO-INTESTINAL SYSTEM		
☐	☐	Stomach or intestinal troubles		
☐	☐	Frequent indigestion, diarrhea, or vomiting problems		
☐	☐	Loss of appetite or difficulty in swallowing		
☐	☐	Jaundice or Hepatitis (A, B, C, or other?)		Local
☐	☐	Liver trouble, gall bladder trouble, or stones		
		ENDOCRINE SYSTEM		
☐	☐	Gland problem, Goiter, or Thyroid condition		
☐	☐	Diabetes (sugar or albumin in urine)		A.M.
☐	☐	Family members with Diabetes or Tuberculosis		

Continued on next page

Patients Initials: _____

Yes	No	Please check appropriate box / circle appropriate answer	Comments	STAFF ONLY
		GENITO-URINARY SYSTEM		
☐	☐	Kidney disease, dialysis, or frequent urination		NSAID
☐	☐	Swollen ankles or eyelids		
		RESPIRATORY SYSTEM		
☐	☐	Respiratory Disease or Tuberculosis		
☐	☐	Asthma, Hay-fever, or Allergies		VENT
☐	☐	Tobacco, Snuff or alcohol habit		
		NERVOUS SYSTEM		
☐	☐	Epilepsy or Convulsions		
☐	☐	Dementia, Alzheimer's, memory loss, psychiatric treatment		
☐	☐	Neuritis, Neuralgia or Numbness		
☐	☐	Parkinson's Disease		
		BLOOD		
☐	☐	Dizziness, fainting spells, or anemia		
☐	☐	Blood disease, Blood transfusion		
☐	☐	Bleeding gums, denied permission to give blood?		
☐	☐	Excessive bleeding following a scratch or cut		INR
		BONES AND JOINTS		
☐	☐	Arthritis, rheumatism, osteoporosis		
☐	☐	Frequent fractures or dislocations		
☐	☐	Joint replacements: Hip, Knee or Shoulder		
		SPECIAL ORGANS		
☐	☐	Eye, Retina surgery, Narrow Angle Glaucoma		N2O
☐	☐	Sinusitis or Headaches, Ear, Nose or Throat trouble		O.S.
☐	☐	Facial Injuries, Hearing Impairment		
		OTHERS		
☐	☐	Tumors, growths, Cysts, or Cancer		
☐	☐	Recent gain or loss of weight		
☐	☐	Scarlet Fever, Pneumonia or a High Fever Disease		
☐	☐	Mumps		
☐	☐	A reaction to Serums, Drugs, Medicines or Latex		
☐	☐	Allergy to Penicillin, Antibiotics or Dental Anesthetics		
☐	☐	Major operations or Hospitalizations, Organ Transplant		
☐	☐	Pregnancy or Menstrual problems		
☐	☐	Skin rash, Hives or other skin problems		
☐	☐	Are you sensitive to any metals (i.e., Nickel) or Latex?		
☐	☐	Do you use any weight loss medications? Used Phen-fen?		
☐	☐	Sexually transmitted diseases, Venereal Disease		
☐	☐	Have you tested HIV positive, or do you have AIDS?		

ASA 1* 2* 3* 4

Patient Signature:_____ Date: _____

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PATIENT MEDICAL HISTORY

Please Mark any questions that you would answer "YES"

- ☐ Are you apprehensive about dental treatment?
- ☐ Have you had problems with previous dental treatment?
- ☐ Do you gag easily?
- ☐ Do you wear dentures?
- ☐ Does food catch between your teeth?
- ☐ Do you have difficulty in chewing your food?
- ☐ Do you chew on only one side of your mouth?
- ☐ Do you avoid brushing any part of your mouth because of pain?
- ☐ Do your gums bleed easily?
- ☐ Do your gums bleed when you floss?
- ☐ Do your gums feel swollen or tender?
- ☐ Have you ever noticed slow healing sores in or around your mouth?
- ☐ Are your teeth sensitive?
- ☐ Do you feel twinges of pain when your teeth come in contact with:
  - ☐ Hot foods or liquids?
  - ☐ Cold foods or liquids?
  - ☐ Sour?
  - ☐ Sweets?
- ☐ Do you take fluoride supplements?
- ☐ Are you dissatisfied with the appearance of your teeth?
- ☐ Do you prefer to save your teeth?
- ☐ Do you want complete dental care?
- ☐ How often do you brush?_____ How often do you floss? _____
- ☐ Does your jaw make noise so that it bothers you or others?
- ☐ Do you clench or grind your jaws frequently?
- ☐ Do your jaws ever feel tired?
- ☐ Does your jaw get stuck so that you can't open freely?
- ☐ Does it hurt when you chew or open wide to take a bite?
- ☐ Do you have ear aches or pain in front of the ears?
- ☐ Do you have any jaw symptoms or headaches upon awaking in the morning?
- ☐ Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?
- ☐ Are you unable to open your mouth as far as you want?
- ☐ Are you aware of an uncomfortable bite?
- ☐ Are you a habitual gum-chewer or pipe smoker?
- ☐ Do you sometimes gasp for air during sleep?
- ☐ Do you snore regularly?
- ☐ Do you have any disease, condition, or problem not listed that you feel we should know about? If so, please describe below.

_____

_____