William A. Vainer, D.D.S.
2100 S. Bascom Avenue, suite #2
Campbell, CA 95008
Tel. (408) 377-9772

Dental Registration and Health History

Date: _____

Patient's Name: _____ SSN: _____

Sex: M F Age: _____ Birth Date: _____ Single Married Widow(er) Separated Divorced

Cell#: _____ Home#: _____ Work#: _____

Answers to the following questions are for our records and will be kept confidential.

Please circle YES or NO to indicate if you have had any of the following:

Chest Pain	YES NO	Fainting or Dizzy Spells	YES NO
Heart Failure	YES NO	Eating Disorder	YES NO
Heart Disease or Attack	YES NO	Epilepsy or Seizures	YES NO
Heart Problems	YES NO	Persistent Cough	YES NO
Liver Disease	YES NO	Tuberculosis	YES NO
Heart Surgery	YES NO	Asthma	YES NO
High Blood Pressure	YES NO	Congenital Heart Problems	YES NO
Heart Murmur	YES NO	Hepatitis A	YES NO
Rheumatic Fever	YES NO	Hepatitis B	YES NO
Psychiatric Treatment	YES NO	Hepatitis C or other	YES NO
Sickle Cell Disease	YES NO	Pacemaker	YES NO
Sinus Trouble	YES NO	Stroke	YES NO
Artificial Joints	YES NO	Drug Addiction	YES NO
Thyroid Disease	YES NO	Cold Sores	YES NO
Anemia	YES NO	Radiation Therapy	YES NO
Blood Transfusion	YES NO	Alcoholism	YES NO
Any Type of Implant	YES NO	Glaucoma	YES NO
Mitral Valve Prolapse	YES NO	Arthritis	YES NO
Herpes	YES NO	Dentures or Partials	YES NO
Steroid Treatment	YES NO	HIV Positive or AIDS	YES NO
Birth Defects	YES NO	Use of Tobacco	YES NO
Hay Fever	YES NO	Jaundice	YES NO
Bruise Easily	YES NO	Kidney Trouble	YES NO
Hemophilia	YES NO	Diabetes	YES NO
Chemotherapy	YES NO	Cancer (Type: _____)	YES NO
Ulcers	YES NO	Auto-Immune Disorder	YES NO
Emphysema	YES NO		
		Other: _____	

1. Have you or any member of your family been seen by us before? YES NO
   If yes, which family member(s)? _____
2. Date of last physical examination: _____ Physician's name: _____
3. Date of last dental examination:_____ Previous Dentist's name: _____
4. Date of last dental x-rays: _____

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5. Are you having any pain or discomfort at this time? YES NO
6. Do you feel nervous about having dental treatment? YES NO
7. Have you ever had a bad dental experience? YES NO
8. Is there anything you dislike about your smile? YES NO
9. Is there anything you'd like to discuss with the dentist in private? YES NO
10. Have you been hospitalized in the past two years? YES NO
11. Have you been under the care of a physician in the past two years YES NO
12. Have you taken any medications or drugs in the past two years? YES NO
13. Are you taking any vitamins, herbal supplements or "cures"? YES NO
14. Have you ever had excessive bleeding that required special treatment? YES NO

ALLERGIES

Aspirin
Barbiturates
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Metals
Other: _____

MEDICATIONS

Please list medications you are currently taking:
_____
_____
_____
Pharmacy:_____

***PRE-MEDICATION (ANTIBIOTICS) MAY BE REQUIRED PRIOR TO YOUR APPOINTMENT.**

Have you ever experienced any of the following?

Clicking? YES NO
Pain in or around your ears? YES NO
Difficulty opening or closing? YES NO
Difficulty chewing? YES NO
Do you have a history of trauma to your jaw? YES NO
Have you ever been diagnosed with TMJ/TMD problems? YES NO
Do you have any sores, lumps or growths in or near your mouth? YES NO
Have you ever had difficult extractions in the past? YES NO
Have you ever had prolonged bleeding following extractions? YES NO
Do you habitually grind or clench your teeth (day or night)? YES NO
Problems with bad breath? YES NO
Does food collect between your teeth? YES NO
Have you ever had oral hygiene instructions? YES NO
Have you ever taken Redux or Pondimin (Fen Phen)? YES NO
Have you ever been told you have gum problems? YES NO
Have you ever needed to see a periodontist? YES NO
Do you now have bleeding gums or any other gum problem? YES NO

Is there anything related to your medical or dental history that you have not indicated above?
If yes, please explain: _____

WOMEN: Are your pregnant? YES NO
If yes, what is your due date: _____
Are you currently breast feeding? YES NO
Are you taking oral contraceptives? YES NO

Signature: _____ Date: _____