Dr. Shahbazian, D.M.D
Office Location (circle):

300 Congress St, Suite 306,
Quincy, MA 02169
(617) 481-9448

157 Washington St
Quincy, MA 02169
(617) 479-7625

MEDICAL HISTORY FORM TODAY'S DATE _____

Name _____ Home Ph# _____

Cell Ph# _____ Work Ph# _____

Email _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ Sex M F Height _____ Weight _____ Marital Status S M

Occupation _____ Name of Employer _____ SS# _____ - _____ - _____

Name of Spouse _____ Closest Relative _____ Ph# _____

Insurance Company _____

Circle Yes or No

Yes No 1. Do you consider yourself in good health?
Yes No 2. Have you been examined by a physician within the past year?
Yes No 3. Has there been any changes in your health this year?
Yes No 4. Have you ever been seriously ill or had any hospitalizations within the last 5 years?
Yes No 5. Do you often feel exhausted or fatigued?
Yes No 6. Do you have chest pain on exertion?
Yes No 7. Do you bruise easily or bleed a long time when you have a cut?
Yes No 8. Have you ever had an unusual reaction to a dental anesthetic or any other drug?
Yes No 9. (**Women**) are you pregnant?
Yes No 10. (**Women**) are you taking birth control pills?
Yes No 11. Do you have a specific dental problem?
Yes No 12. If so, is the problem related to an accident? Please explain.

_____

Yes No 13. Do your gums bleed?
Yes No 14. Are you troubled with bad breath or sensitive teeth?
Yes No 15. Have you noticed any loosening of your teeth?
Yes No 16. Do you have sensitive teeth?
Yes No 17. Do your jaws lock when opening your mouth?
Yes No 18. Would you like to whiten your teeth with bleaching?

Name of Primary Physician _____ **Phone** _____

Address _____

Answer (Y)es or (**N)o** in **ALL** spaces below: Have you **ever** had any of the following?

( ) Rheumatic fever ( ) Heart murmur ( ) High blood pressure ( ) Low blood pressure

( ) Emphysema ( ) Bronchitis ( ) Arthritis ( ) Swollen joints

( ) Pacemaker ( ) Hepatitis ( ) Venereal Disease ( ) Cancer

( ) Stroke ( ) Heart attack ( ) Persistent Cough ( ) Epilepsy / Seizure

( ) Jaundice ( ) Aids / HIV ( ) Asthma / Hay fever ( ) Herpes

( ) Angina ( ) Sinus problems ( ) Nickel/Jewelry allergy ( ) Hyperthyroidism

( ) Hemophilia ( ) Diabetes ( ) Artificial Prosthesis ( ) Liver Disease

( ) Kidney Disease ( ) Paget's Disease ( ) Alcohol/Drug Addiction ( ) Mental Health Issues

( ) Anemia ( ) Tuberculosis ( ) Osteoporosis ( ) Smoker

( ) Latex Allergy ( ) Radiation/Chemotherapy

( ) Congenital Heart Disease

MEDICATIONS

CURRENT MEDICATIONS

_____

_____

_____

_____

ALLERGIES TO MEDICATIONS / LATEX

_____

_____

_____

_____

I certify that I have read and understand the above, and 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.

Patient Signature_____

Today's Date _____

Dentist Signature _____