DeLand Implant Dentistry

Dr. Jayraj Patel, DMD

150 McGregor Road, Deland, FL 32720/Tel. 386.738.2006 / Fax 386.738.2007/ www.delandimplants.com

Medical History Update

Patient Name: _____ **Phone: Home:** _____
Address: _____ **Work:** _____
City: _____ **State:** _____ **ZIP:** _____ **Cell:** _____
E-mail address: _____
Your preference for contact would be: ____Home ____ Cell ____ Email_____ Text

1. Has there been any change in your health since your last appointment? __Yes __No
For what conditions? _____
2. Do you have any allergies (or adverse reactions) to any medications? __Yes __ No
If so, what _____
3. Are you aware of jaw joint sound? ___ Yes ___ No
4. Did you ever have jaw joint sound? ___ Yes ___ No
5. Do you ever have pain or soreness in front of your ears? ___ Yes ___ No
6. Do you have ear pain? ___ Yes ___ No
7. Do you wake up with your jaws sore or tired? ___ Yes ___ No
8. Do you ever have difficulty opening your jaw widely? ___ Yes ___ No
9. Do you avoid eating certain foods because of pain or discomfort? ___ Yes ___ No
10. Do you snore? ___ Yes ___ No
11. Has anyone reported that you choke or gasp for air while sleeping? ___ Yes ___ No
12. Do you wake up refreshed? ___ Yes ___ No
13. Are you excessively tired during the day? ___ Yes ___No
14. Do you have high blood pressure? ___ Yes ___ No
15. Do you have any other concern with your teeth or gums:___ Yes ___ No

If yes, explain: _____

List all medications you are taking (or supposed to take) including over the counter medications, aspirin, birth control pills or hormones (if none, so state):

Medication - Dosage - Time / Day

_____
_____
_____
_____
_____
_____
_____

Patient's Signature: _____ **Date:** _____