Scott B. Klimaj, D.M.D.
7 Smith Avenue, Suite 102
Greenville, RI 02828

Patient Name: _________________________________ Date of Birth: _________

Medical History
Physician's Name: ______________________________________
Address: ______________________________________
Phone #: ______________________________________

Date of last check-up: ______________
Are you currently under the care of a physician? ___ yes ____ no
Are you pregnant? _____ yes _____ no
Do you smoke or use tobacco? _____ yes ______ no
Are you taking Biphosphates? _____ yes _____ no

Please list all medications you are currently taking:

Please list any drugs/materials that may cause an allergic reaction:

Dental History
Are you in pain? ____ yes ____ no
Do you require Pre-Medication? _____ yes _____ no
Have you ever had TMJ/TMD? _____ yes _____ no
Your current dental health is: _____ good ______ fair ______ poor
Are your teeth sensitive to hot or cold? ____ yes ____ no
Are your teeth loose? _____ yes _____ no
Do your gums bleed? _____ yes _____ no
Have you ever been diagnosed with periodontal disease? _____ yes ____ no

Check all that apply

Abnormal bleeding		Cancer		Fainting Spells/Dizziness	
Aids/HIV		Chemotherapy		Frequent Cough	
Alzheimer's disease		Chest pains		Frequent Diarrhea	
Anaphylaxis		Cold Sores		Frequent Headaches	
Anemia		Congenital Heart Disorder		Genital Herpes	
Angina		Convulsions		Glaucoma	
Arthritis/Gout		Cortisone Medicine		Hay Fever	
Artificial Heart Valve		Diabetes		Heart Attack/Failure	
Artificial Joint		Drug Addiction		Heart Murmur	
Asthma		Easily Winded		Heart Pace Maker	
Blood Disease		Emphysema		Heart Trouble/Disease	
Blood Transfusion		Epilepsy/Seizures		Hemophilia	
Breathing Problem		Excessive Bleeding		Hepatitis A	
Bruise Easily		Excessive Thirst		Hepatitis B or C	

Check all that apply

Herpes		Psychiatric care		Stroke	
High Blood Pressure		Radiation Treatment		Swelling of Limbs	
Hives or rash		Recent Weight Loss		Thyroid Disease	
Hypoglycemia		Renal Dialysis		Tonsillitis	
Irregular Heartbeat		Rheumatic Fever		Tuberculosis	
Kidney Problems		Rheumatism		Tumors or Growths	
Leukemia		Scarlet Fever		Ulcers	
Liver Disease		Shingles		Venereal Disease	
Low Blood Pressure		Sickle Cell Disease		Yellow Jaundice	
Lung Disease		Sinus Trouble			
Mitral Valve Prolapse		Spina Bifida			
Parathyroid Disease		Stomach Disease			

Do you have any medical condition or serious health issue not listed above?
If so, please explain. ____

I, _________________, have received/read a copy of this office's Notice of Privacy Practices.
(Print Name)

Patient Signature: ____________________________ **Date**: _______________