David Levine, DDS

GENERAL DENTISTRY | SLEEP MEDICINE | ORTHODONTIC SERVICES

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Name_____Date of Birth_____

Social Security #_____
Physician_____Phone Number_____

MEDICAL HISTORY

1. Are you currently under the care of a physician?..... Y ..... N
2. Do you take any medication on a regular basis?..... Y ..... N
3. Do you have high or low blood pressure?..... Y ..... N
4. Do you have diabetes, or any kidney, liver, thyroid, or lung disease?.....Y ..... N
5. Did you ever have rheumatic fever?..... Y ..... N
6. Have you ever had abnormal bleeding following an extraction of a tooth or a cut?..... Y ..... N
7. Have you ever had an abnormal reaction to penicillin or other medication?..... Y ..... N
8. Have you ever had an abnormal reaction to any local anesthetic?..... Y ..... N
9. Are you there any medications you have been told not to take?..... Y ..... N
10. Are you experiencing any dental pain or facial pain?..... Y ..... N
11. Have you ever had a bad dental experience?..... Y ..... N
12. Have you visited a dentist in the past year?..... Y ..... N
13. Do you consider yourself in good health?..... Y ..... N
14. Have you been told you snore?..... Y ..... N
15. Are you tired during the day, need caffeine to keep you going throughout the day or fall asleep while at rest?..... Y ..... N
16. Do you use a CPAP machine or been told to but aren't using one?..... Y ..... N

Please comment or explain above answers:_____

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SIGNATURE_____DATE_____