Michael Gruber, DMD, FAGD
Michela Russo, DDS
Anthony T. Chin
Periodontology Specialty Permit #3925

Gruber Dental™
Restorative and Cosmetic Dentistry

Alexa Gruber, DDS
Marc J. Novak, DMD
Edward Rockford, DMD

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No
_____
3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? _____
Aredia	Reclast	Zometa	When did you stop? _____

8. Please list other medications you are taking:
_____
_____

Have you ever had any of the following?

Abnormal Bleeding	☐Yes ☐ No	Fainting Spells	☐Yes ☐ No	Low Blood Pressure	☐Yes ☐ No
Alcohol/ Drug Abuse	☐Yes ☐ No	Frequent Headaches	☐Yes ☐ No	Mitral Valve Prolapse	☐Yes ☐ No
Anemia	☐Yes ☐ No	Glaucoma	☐Yes ☐ No	Pacemaker	☐Yes ☐ No
Arthritis	☐Yes ☐ No	Hay Fever	☐Yes ☐ No	Psychiatric Problems	☐Yes ☐ No
Artificial Joints	☐Yes ☐ No	Heart Attack	☐Yes ☐ No	Radiation Treatement	☐Yes ☐ No
Artificial Heart Valve	☐Yes ☐ No	Heart Murmur	☐Yes ☐ No	Rheumatic Fever	☐Yes ☐ No
Asthma	☐Yes ☐ No	Heart Surgery	☐Yes ☐ No	Seizures	☐Yes ☐ No
Blood Transfusion	☐Yes ☐ No	Hemophilia	☐Yes ☐ No	Shingles	☐Yes ☐ No
Cancer/ Chemotherapy	☐Yes ☐ No	Hepatitis (A, B, C/D)	☐Yes ☐ No	Sickle Cell Disease	☐Yes ☐ No
Colitis	☐Yes ☐ No	Herpes/ Fever Blisters	☐Yes ☐ No	Sinus Issues	☐Yes ☐ No
Congenital Heart Defect	☐Yes ☐ No	High Blood Pressure	☐Yes ☐ No	Stroke	☐Yes ☐ No
Diabetes	☐Yes ☐ No	HIV+/ AIDS	☐Yes ☐ No	Thyroid Problems	☐Yes ☐ No
Difficulty Breathing	☐Yes ☐ No	Hospitalizations	☐Yes ☐ No	Tuberculosis (TB)	☐Yes ☐ No
Emphysema	☐Yes ☐ No	Kidney Disease	☐Yes ☐ No	Ulcers	☐Yes ☐ No
Epilepsy/ Seizures	☐Yes ☐ No	Liver Disease	☐Yes ☐ No	Venereal Disease	☐Yes ☐ No

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Dental History

1. Date of last dental exam:_____ Date of last dental x-rays: _____
2. Previous dentist's name / location:_____

3. Are you having tooth or gum pain at this time?	Yes	No
4. Do you feel nervous about having dental treatment?	Yes	No
5. Have you ever had a bad experience in a dental office?	Yes	No
6. Do your gums bleed when brushing / flossing?	Yes	No
7. Do you like your smile?	Yes	No
8. Would you like whiter teeth?	Yes	No
9. Do you smoke or use tobacco in any other form?	Yes	No
10. Would you be interested in discussing ways to improve your smile?	Yes	No

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking in jaw joint	Yes	No	Sensitivity to:	Hot	Cold	Sweets	Biting
Pain in or around your ears	Yes	No	Swelling		Bleeding Gums		
Difficulty opening or closing	Yes	No	Bad Taste		Bad Breath		
Difficulty chewing	Yes	No	Food Catching		Tooth Pain		
History of trauma to jaw or face	Yes	No	Clenching		Grinding		
Diagnosis of TMJ/TMD	Yes	No	Other: _____				

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: _____ Date_____

Doctor's Signature_____

Doctor's Notes:

Chief Complaint:

Risk Factors: