

**Top Down Dental**  
**Nancy Nehawandian, DDS, MAGD**

**GUEST INFORMATION**

Last Name:	First Name:	Middle Initial:
Preferred Name:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Birth date:	Marital Status:	# of Children:
Address:	City:	State: Zip:
Phones: Home:	Work:	Cell:
Email:		
Social Security:		
Employer: Occupation:		
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you a full time student? If yes, name of School?		
Emergency Contact:		Phone:

**IF THE GUEST IS A MINOR, PLEASE FILL OUT THE BOX BELOW**

<input type="checkbox"/> Parent <input type="checkbox"/> Guardian Name:
Address: City: State: Zip:
Social Security:
Will we be assisting you with insurance? <input type="checkbox"/> Y <input type="checkbox"/> N

**MEDICAL HISTORY**

**I. Please Answer the following Questions**

Your current oral health is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
<input type="checkbox"/> Y <input type="checkbox"/> N Wisdom teeth extractions <input type="checkbox"/> Y <input type="checkbox"/> N Braces/Orthodontics <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal Surgery	
<input type="checkbox"/> Y <input type="checkbox"/> N Problems with previous dental work? Please Explain:	
Your current overall health is <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Please Explain:	
Physician's Name:	Phone: City:
Date and nature of last visit:	Date of Last Physical Exam:
Weight: Height:	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Has there been any change in your health within the last year?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you gone to the hospital/emergency room or had any serious illness or surgeries in the past three years?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have any Drug Allergies?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Anything you would like to discuss with the doctor in private?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you take antibiotics before dental treatments?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you taking or have taken Fen-phen or Bisphosphonate (Fosamax)?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you use any form of tobacco (e.g. Cigarettes, chew, vape)? How much?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you drink alcohol? How much?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you in pain now?
<b>Family History:</b> <input type="checkbox"/> Cancer <input type="checkbox"/> Dementia/Alzheimer's <input type="checkbox"/> Diabetes <input type="checkbox"/> GERD <input type="checkbox"/> Heart Disease <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other	

**Please list ALL Prescription/Over the Counter Drugs or Herbal supplements and the dosage you are currently taking.**

## II. Please check if you have or had any of the following

<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Cough, persistent	<input type="checkbox"/> Heart Disease/Defect	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> AIDS/HIV positive	<input type="checkbox"/> Cough up blood	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rapid Weight Loss/Gain
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Dental Anxiety	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Dental Implants	<input type="checkbox"/> Herpes, Type?	<input type="checkbox"/> Restricted/Special Diet
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rheumatic/Scarlet Fever
<input type="checkbox"/> Arthritis/ Rheumatism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hospitalized	<input type="checkbox"/> Ringing in the ear (Tinnitus)
<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sense of Change of Balance
<input type="checkbox"/> Artificial Heart valve	<input type="checkbox"/> Difficulty chewing	<input type="checkbox"/> Jaw Joint Pain	<input type="checkbox"/> Sensitive Teeth
<input type="checkbox"/> Asthma	<input type="checkbox"/> Difficulty Swallowing (Dysphasia)	<input type="checkbox"/> Jaw Joint Noise/Clicking	<input type="checkbox"/> Shingles
<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Discomfort with TMJ	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Back/Postural problems	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Latex Sensitivity	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Bacterial Infections/MRSA	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Bell's Palsy	<input type="checkbox"/> Ear congestion/Itchy	<input type="checkbox"/> Loose Teeth	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Skin Disease/Rash
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Material/Food Allergies	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Eye Disease	<input type="checkbox"/> Medical Implants	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Cancer	<input type="checkbox"/> Facial or Jaw Pain	<input type="checkbox"/> Metal Rods/Pins	<input type="checkbox"/> Swelling of feet or ankles
<input type="checkbox"/> Chemotherapy/Radiation	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cervical Pain	<input type="checkbox"/> Fever/Cold Blisters	<input type="checkbox"/> Nail Biting Habit	<input type="checkbox"/> Tingling of Fingertips
<input type="checkbox"/> Chest Pain (Angina)	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Nervous/Anxious	<input type="checkbox"/> Tonsillectomy (have had)
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Gag Reflex	<input type="checkbox"/> Neck and Shoulder aches	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> GERD	<input type="checkbox"/> Old or broken fillings	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Clenching or Grinding	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tumors
<input type="checkbox"/> Colitis/Ulcer	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Pressure behind eyes	<input type="checkbox"/> Vertigo (Dizziness)
<input type="checkbox"/> Cortisone treatments	<input type="checkbox"/> Heart Attack/Surgery	<input type="checkbox"/> Previous gum treatment	<input type="checkbox"/> Worn and/or discolored teeth

## III. Women Only

<input type="checkbox"/> YES <input type="checkbox"/> NO Are you pregnant? Expected delivery date?
<input type="checkbox"/> YES <input type="checkbox"/> NO Are you nursing?
<input type="checkbox"/> YES <input type="checkbox"/> NO Are you taking birth control pills?
<input type="checkbox"/> YES <input type="checkbox"/> NO Do you have a history of miscarriages? When?
<input type="checkbox"/> YES <input type="checkbox"/> NO Have you reached menopause?

## IV. Check the Box if your answer is yes to any of the following questions:

<input type="checkbox"/> YES <input type="checkbox"/> NO Snoring (Do you snore?)
<input type="checkbox"/> YES <input type="checkbox"/> NO Tired (Do you often feel tired, fatigued, or sleepy during the daytime?)
<input type="checkbox"/> YES <input type="checkbox"/> NO Observed (Has anyone observed you stop breathing during your sleep?)
<input type="checkbox"/> YES <input type="checkbox"/> NO Blood Pressure (Do you have or are you being treated for high blood pressure?)
<input type="checkbox"/> YES <input type="checkbox"/> NO BMI (BMI more than 25)
<input type="checkbox"/> YES <input type="checkbox"/> NO Age over 40 years old
<input type="checkbox"/> YES <input type="checkbox"/> NO Neck circumference greater than 16 in (40cm)
<input type="checkbox"/> YES <input type="checkbox"/> NO Gender male
STOP-BANG Scoring Model: High Risk of OSA if answered Yes to three or more items above.

**Is there anything else about your health or having dental treatment that you would like us to know?**

**NOTE: Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to notify Dr. Nehawandian of any changes in my health or medications. I will not hold Dr. Nehawandian or any member of her team, responsible for any errors or omissions I may have made in the completion of this form. I understand that if Dr. Nehawandian determines that there may be a potentially compromised situation, medical consultation may be needed prior to commencement of dental treatment.

Patient/Guardian's Signature

Date

Doctor's Signature

Date