Eden Baluyot Vincent, D.M.D., LLC

508 Pleasant Valley Way
West Orange, NJ 07052
Tel. (973) 731-0087 Fax (973) 731-0024

Medical History

I understand that providing incorrect or omitting information can be dangerous to my health

Primary Physician: _____ Phone: (_____)_____ -_____

Pharmacy: _____ City: _____ State:_____ Phone: (_____)_____ -_____

Healthy History *Please check and circle all that apply*

Heart Murmur, MVP	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	**Allergies**	
Heart Attack, Angina	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Latex; Rubber	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Epilepsy; Seizures; Fainting	☐ Yes ☐ No	Antibiotics; Penicillin	☐ Yes ☐ No
Artificial Joints/Pins/Valves	☐ Yes ☐ No	Acid reflux; Heartburn; GERD	☐ Yes ☐ No	Local Anesthesia "Novocain"	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Hyperthyroid; Hypothyroid	☐ Yes ☐ No	Narcotics; Codeine	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No	Sulfa Drugs	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Metals (Nickel, Mercury, etc.)	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Blood Disorders; Anemia	☐ Yes ☐ No	Other: _____	
Kidney Disease	☐ Yes ☐ No	Allergies; Sinus Problem	☐ Yes ☐ No	**Women:**	
Liver Disease, Hepatitis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Pregnant	☐ Yes ☐ No
Stomach Ulcer	☐ Yes ☐ No	Tobacco Use	☐ Yes ☐ No	Nursing	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Chemical Dependency	☐ Yes ☐ No	Birth Control Hormones	☐ Yes ☐ No

---

Do you snore? ☐ Yes ☐ No Have you been told that you occasionally snore? ☐ Yes ☐ No Are you using or have trouble using a CPAP device? ☐ Yes ☐ No

---

Dental History

Previous Dentist: _____ City: _____ State:_____ Phone: (_____)_____ -_____

Reason for today's visit: _____ Last Exam and Cleaning: _____/_____/_____

Bleeding gums when brushing or flossing	☐ Yes ☐ No	Periodontal treatment treatment/surgery	☐ Yes ☐ No
Sensitivity to any of the following hot, cold, sweets	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No
Sores or growth in your mouth	☐ Yes ☐ No	Head, neck, or jaw injuries/trauma	☐ Yes ☐ No
Pain	☐ Yes ☐ No	Grinding teeth (day; night; both)	☐ Yes ☐ No
Difficult extractions or prolonged bleeding	☐ Yes ☐ No	Clicking or popping jaw	☐ Yes ☐ No
Bad Breath	☐ Yes ☐ No	Food collection between certain teeth	☐ Yes ☐ No

Changes/ Initial/Date	Changes/ Initial/Date	Changes/ Initial/Date	Changes/ Initial/Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To the best of my knowledge, the above information is complete and correct.
I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

_____ Date:_____/_____/_____

Patient or Guardian Signature