SENIOR smile
Namita K. Thapar-Dua, DDS
Providing Mobile Dental Care
Serving Maryland, DC & Virginia
301.875.7477

MEDICAL HISTORY (Homebound)

Patient Information

Full Name: _____ Date of Birth: _____
First *Last*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Please Answer the Questions Below

Do you have any Food or Medical Allergies? NO ☐ YES ☐ If yes, list them: _____

Have you ever had a Joint (Hip, Knee, other) Replacement(s)? NO ☐ YES ☐

- How long ago was the procedure? Please indicate: _____

- Do you take any Prophylactic Pre-Medications (for example, an ANTIBIOTIC) before any of your dental visits? NO ☐ YES ☐ Please indicate: _____

Are you taking any Blood Thinner(s)? (daily or occasionally) NO ☐ YES ☐ Please indicate: _____

Do you wear Dentures? NO ☐ YES ☐

- Complete and/or partial dentures? Please indicate: _____

- Upper and/or lower dentures? Please indicate: _____

- How long have you had your dentures: Please indicate: _____

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Do your Gums Bleed while brushing? NO ☐ YES ☐

Do you have Sensitivity? NO ☐ YES ☐ Please indicate: _____

- If so, where? Please indicate: _____

Do you have Low/High Blood Pressure? NO ☐ YES ☐ Please indicate: _____

- If so, do you take medication(s) for it: Please indicate: _____

Do you have a Pacemaker or Defibrillator? NO ☐ YES ☐ Please indicate: _____

- If so, when was it placed? Please indicate: _____

Do you have Cancer? NO ☐ YES ☐

- If so, what kind of cancer? Please indicate: _____
- Are you taking any medication(s) for it? Please indicate: _____
- Are you doing any form of treatment? Please indicate: _____

Have you been exposed to a Sexually Transmitted Disease(s)? NO ☐ YES ☐

- If so, which one(s)? Please indicate: _____
- Have you been/or being treated? Please indicate: _____

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Are you HIV Positive? NO ☐ YES ☐

- If so, when were you diagnosed? Please indicate: _____
- Have you been /or being treated? Please indicate: _____

Do you have AIDS? NO ☐ YES ☐

- If so, when were you diagnosed? Please indicate: _____
- If so, are you under any treatment? Please indicate: _____

Have you traveled outside the country within the past (6) months? NO ☐ YES ☐

- If so, when did you travel outside? Please indicate: _____
- If so, where was it that you traveled to? Please indicate: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Furthermore, I am giving consent to release privileged information such as the medical history, so the doctor can properly perform treatment.

Print Name: _____ Date: _____
Patient and/or Responsible Party

Signature: _____ Date: _____
Patient and/or Responsible Party