

MEDICAL HISTORY

1. Are you having any pain or discomfort at this time?.....YES NO
 2. Have you been a patient in the hospital during the past two years?..... YES NO
 3. Have you been under the care of a medical doctor during the past two years?.....YES NO
- Physician's Name _____ Phone No. _____
Address _____
4. Are you now taking any medications, drugs, or pills?..... YES NO
If yes, please list: _____
 5. Are you aware of being allergic to or have you ever reacted adversely to any medication or substances? YES NO
If yes, please list: _____

Indicate which of the following you have had or have at the present time. Circle yes or no for each question.

Heart Failure YES NO	Artificial Joints(hip, knee, etc... YES NO	Hepatitis A, B, or C.....YES NO
Heart Disease or Attack... YES NO	Kidney Trouble.....YES NO	Venereal Disease.....YES NO
Angina Pectoris..... YES NO	Ulcers.....YES NO	A.I.D.S.....YES NO
Congenital Heart Disease. YES NO	Diabetes.....YES NO	H.I.V. Positive.....YES NO
Heart Murmur.....YES NO	Thyroid Problems.....YES NO	Cold Sores/Fever Blisters.....YES NO
High Blood Pressure..... YES NO	Glaucoma..... YES NO	Blood Transfusion.....YES NO
Arteriosclerosis..... YES NO	Cosmetic Surgery.....YES NO	Hemophilia..... YES NO
Mitral Valve Prolapse..... YES NO	Emphysema..... YES NO	Anemia.....YES NO
Artificial Heart Valve..... YES NO	Chronic Cough.....YES NO	Sickle Cell Disease.....YES NO
Heart Pacemaker.....YES NO	Tuberculosis.....YES NO	Bruise Easily.....YES NO
Heart Surgery..... YES NO	Asthma.....YES NO	Liver Disease.....YES NO
Rheumatic Fever.....YES NO	Hay Fever.....YES NO	Yellow Jaundice..... YES NO
Arthritis..... YES NO	Allergies or Hives.....YES NO	Epilepsy or Seizures.....YES NO
Rheumatism..... YES NO	Sinus Trouble.....YES NO	Fainting or Dizzy Spells..... YES NO
Cortisone Medicine..... YES NO	Radiation Therapy.....YES NO	Nervousness.....YES NO
Drug Addiction..... YES NO	Chemotherapy.....YES NO	Psychiatric Treatment.....YES NO
Stroke..... YES NO	Hepatitis A (infectious).....YES NO	Cancer or Tumors.....YES NO

- Do you have or have had any diseases, conditions, or problems not listed?..... YES NO
If yes, please list: _____

DENTAL HISTORY

1. Are you having any specific problems with your teeth, gums or mouth?.....YES NO
2. Are your teeth sensitive to hot, cold, or sweets?..... YES NO
3. Do you have any fever blisters, mouth ulcers or sores on your lips or mouth?..... YES NO
4. Do you often have chapped lips, cracked or raw places on corners of mouth?..... YES NO
5. Do your gums bleed after brushing; are they often sore or tender?..... YES NO
6. Do you have difficulty swallowing, chewing or do you frequently chew on one side only?.....YES NO
7. Do you frequently wedge food between your teeth?.....YES NO
8. Have you worn braces for straightening your teeth?.....YES NO
9. In general, do dental treatments cause you much concern or worry?..... YES NO
10. Do you chew or smoke tobacco in any form?.....YES NO
11. Are you dissatisfied with the appearance of your teeth?..... YES NO
12. Do you use a hard, medium, or soft tooth brush? _____
13. When do you brush your teeth: morning, noon or night? _____
14. How many times a week do you use toothpicks? _____ Dental Floss? _____
15. Do you clench or grind your teeth?..... YES NO.
16. Do you notice popping, clicking or soreness of the jaws or points just in front of ears?..... YES NO
Which side? _____
17. Do you ever have frequent headaches, earaches, stiffness or soreness in your neck?..... YES NO
18. When was your last dental check-up? _____ dental x-rays? _____ dental cleaning? _____

I Understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

FOR WOMEN ONLY:

Are you pregnant? YES NO What month? ____ Are you nursing? YES NO Are you taking birth control pills? YES NO