NAME: ________________________ **DATE:** ________________________

AGE: _______ **HEIGHT:** _________ **WEIGHT** ______

PHYSICIANS NAME & TEL:____

LAST MEDICAL EXAMINATION: _______________ **WAS BLOOD DRAWN?** ___ **FINDINGS?** ________________

GENERAL DENTIST: ____

PRESENT DENTAL COMPLAINTS: ____

HAVE FAMILY OR FRIENDS BEEN TREATED HERE? ____

Do you have or have you ever had	Y	N	Do you have or have you ever had	Y	N
HEPATITIS, JAUNDICE OR LIVER DISEASE			NITROUS OXIDE SEDATION		
EPILEPSY, CONVULSIONS OR FAINTING SPELLS			ANTICOAGULANTS (BLOOD THINNERS)		
RHEUMATIC FEVER			BLOOD TRANSFUSION		
HEART MURMUR OR VALVE PROBLEMS			EMOTIONAL PROBLEMS OR TENSION		
HEART TROUBLE OR STROKE			NERVOUS BREAKDOWN		
ANGINA PECTORIS			CORTISONE MEDICATION		
HIGH OR LOW BLOOD PRESSURE (CIRCLE)			PROSTATE TROUBLE		
HEART PACEMAKER			ALCOHOLISM		
SHORTNESS OF BREATH			DRUG ADDICTION		
CHEST PAINS			EATING DISORDER (ANOREXIA, BULIMIA, ETC.)		
ARTIFICIAL HEART VALVE			ANY SERIOUS DISEASE OR CONDITION NOT LISTED		
SWELLING IN ANKLES			**ARE YOU**:		
TUBERCULOSIS			PRESENTLY UNDER A PHYSICIAN'S CARE		
KIDNEY DISEASE OR INFECTION			TAKING ANY MEDICATION NOW (LIST BELOW)		
DIABETES			OR WITHIN THE PAST YEAR		
A. ANY BLOOD RELATIVES			TAKING VITAMINS		
B. DO YOU URINATE FREQUENTLY?			ALLERGIC TO DENTAL ANESTHETIC		
C. ARE YOU OFTEN THIRSTY?			OFTEN EXHAUSTED OR FATIGUED		
ARTHRITIS OR RHEUMATISM			SUBJECT TO FREQUENT HEADACHES		
ARTIFICIAL JOINT REPLACEMENT			A NERVOUS PERSON		
ORTHOPEDIC SCREWS, PINS, ETC			UNDER UNUSUAL STRESS OR EMOTIONAL TENSION		
STOMACH OR DUODENAL ULCERS			TAKING NERVE OR SLEEPING MEDICATION		
RADIATION OR CHEMOTHERAPY			OFTEN UNHAPPY OR DEPRESSED		
GLAUCOMA			TAKING ANTIDEPRESSION MEDICATION		
ASTHMA, HAY FEVER OR ALLERGIES (CIRCLE)			HAVE YOU RECENTLY HAD A WEIGHT CHANGE OF 10 POUNDS OR MORE		
DRUG REACTION TO CODEINE, TETRACYCLINE,			DO YOU BRUISE EASILY		
PENICILLIN, DEMEROL, VALIUM,			DO YOU WEAR CONTACT LENSES		
ERYTHROMYCIN, PERCOCET, PERCODAN, ,			DO YOU SMOKE_____HOW MUCH		
BARBITURATES, ASPIRIN, OTHER (CIRCLE)			DID YOU EVER SMOKE___QUIT WHEN		
EMPHYSEMA OR CHRONIC BRONCHITIS			IS YOUR DIET WELL-BALANCED		
ARTERIOSCLEROSIS			DO YOU SNACK BETWEEN MEALS		
THYROID OR PARATHROID DISEASE			COFFEE/TEA__________# CUPS PER DAY_______		
VENEREAL DISEASE			SOFT DRINKS__________ # PER DAY ___________		
GENITAL HERPES			**IF FEMALE**		
SURGERY			ARE YOU PREGNANT _______ NURSING _______		
HOSPITALIZATION FOR ILLNESS OR SURGERY			DO YOU ANTICIPATE BECOMING PREGNANT		
HIVES OR SKIN RASH			TAKING ANTI-PREGNANCY PILL		
CANCER OR ABNORMAL GROWTH			BLEED EXCESSIVELY OR HAVE PROBLEMS WITH MENSTRUAL CYCLE		
ANEMIA OR BLOOD DISORDER			PRESENTLY IN (OR POST) MENOPAUSE		
ABNORMAL BLEEDING			TAKING HORMONES		
AIDS			TAKEN FEN-PHEN OR REDUX		
AIDS ANTIBODY (HIV OR HTLV-III) POSITIVE			TAKEN MEDICATION FOR OSTEOPOROSIS/OSTEOPENIA		

MEDICAL HISTORY NOTES / MEDICATIONS ____

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PLEASE SEE OVER FOR DENTAL HISTORY ▼

DENTAL HISTORY

	Y	N
DO YOU FEAR DENTAL TREATMENT?		
HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (PYORRHEA)?		
HAVE YOU EVER HAD TRENCH MOUTH?		
DO YOUR GUMS BLEED?		
DO YOU HAVE DIFFICULTY CHEWING YOUR FOOD?		
DO YOU GRIND OR CLENCH YOUR TEETH?		
DO YOU HAVE A BITE GUARD/SPLINT?		
ARE SPACES DEVELOPING BETWEEN YOUR TEETH?		
HAVE YOU NOTICED YOUR BITE CHANGING?		
ARE YOU AWARE OF BREATH ODOR?		
HAS A DENTIST, HYGIENIST OR ASSISTANT SHOWN YOU HOW TO CLEAN YOUR TEETH?		
IF YES, DO YOU USE THIS METHOD TO CLEAN YOUR TEETH NOW?		
DO YOU HAVE FREQUENT COLD/CANKER SORES?		
DO YOU FREQUENTLY BREATHE THROUGH YOUR MOUTH?		
DO YOU HAVE PAIN IN THE JAW JOINTS (TMJ)?		
HAVE YOU EVER HAD ORTHODONTIC TREATMENT TO STRAIGHTEN YOUR TEETH?		
HAVE YOU EVER HAD PROBLEMS WITH EXTRACTIONS?		
DOES FOOD WEDGE BETWEEN YOUR TEETH?		
HAS ANY MEMBER OF YOUR FAMILY LOST ALL OF THEIR TEETH?		
WOULD YOU BE TREMENDOUSLY DISTURBED IF YOU LOST ALL YOUR TEETH?		
ARE YOU HAVING PAIN OR DISCOMFORT AT THIS TIME?		
HAVE YOU HAD ANY GUM BOILS OR GUM SWELLING?		
ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH		

WHEN WAS YOUR LAST DENTAL CLEANING? ____________________

HOW OFTEN HAVE YOUR TEETH BEEN CLEANED IN THE PAST 3 YEARS? ____________________

HOW LONG HAVE YOU BEEN A PATIENT OF YOUR PRESENT DENTIST? ____________________

HOW LONG HAVE YOU KNOWN ABOUT YOUR GUM CONDITION? ____________________

ARE YOUR TEETH SENSITIVE TO **HOT** __________ **COLD** __________ **SWEET** __________

HOW WOULD YOU RATE YOUR PAST DENTAL CARE? ____________________

PLEASE CHECK ANY OF THE FOLLOWING ITEMS YOU USE IN MOUTH CARE:

HAND TOOTHBRUSH		TOOTHPICKS	
ELECTRIC TOOTHBRUSH		PERIO AID	
PROXABRUSH		STIMUDENTS	
DENTAL FLOSS		GUM STIMULATOR	
FLOSS HOLDER		RUBBER TIP	
MOUTHWASHES		TOOTHPASTE	
WATER SPRAY DEVICE		OTHER	

DENTAL HISTORY NOTES ____________________

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TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES TO MY HEALTH, OR IF MY MEDICATIONS CHANGE, I WILL INFORM THE DOCTOR OR HIS STAFF AT THE NEXT APPOINTMENT .

Date ____________________ Patient’s signature ____________________