PATIENT'S NAME_____ _____/_____/_____

Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER

1. Physician's Name_____
   Address_____
2. Are you under a physician's care?.....YES NO
   Since when_____Why_____
3. When was your last complete physical exam?_____
4. Are you taking any medication?.....YES NO
5. Do you routinely take health related substances?.....YES NO
6. Are you allergic to any medications or substances?.....YES NO
7. Do you have any other allergies?.....YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?.....YES NO
9. Are you sensitive to any metals?.....YES NO
10. Are you sensitive to latex?.....YES NO
11. Are you pregnant or suspect you may be?.....YES NO
12. Do you use any birth control medications?.....YES NO
13. Have you ever been treated for or been told you might have a heart disease?.....YES NO
14. Do you have a pacemaker or an artificial heart valve implant?.....YES NO
15. Have you ever had rheumatic fever.....YES NO
16. Are you aware of any heart murmurs?.....YES NO
17. Do you have high or low blood pressure?.....YES NO
18. Have you ever had a serious illness or major surgery?.....YES NO
    If so, explain_____
19. Have you ever had radiation treatment, chemo treatment for a tumor, growth or other condition?.....YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism?.....YES NO
21. Do you have any artificial joints/prothesis?.....YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc?.....YES NO
23. Have you ever bled excessively after being cut or injured?.....YES NO
24. Do you have any stomach problems?.....YES NO
25. Do you have any kidney problems?.....YES NO
26. Do you have any liver problems?.....YES NO
27. Are you diabetic?.....YES NO
    If so, how is it controlled?.....YES NO
28. Do you have asthma?.....YES NO
29. Do you have epilepsy or other seizure disorders?.....YES NO
30. Do you or have you had venereal disease?.....YES NO
31. Have you tested HIV positive?.....YES NO
32. Do you have AIDS?.....YES NO
    If so, what is your T-Cell count?_____
33. Have you had or do you test positive for hepatitis?.....YES NO
34. Do you or have you had T.B.?.....YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco?.....YES NO
36. Do you consume alcoholic beverages?.....YES NO
37. Do you habitually use controlled substances?.....YES NO
38. Have you had psychiatric treatment?.....YES NO
39. Do you have any disease, condition, or problem not listed? If so, explain_____
    _____
40. Is there anything else we should know about your health that we have not covered in this form?
    _____
41. Would you like to speak to the Doctor privately about any problem?.....YES NO

COMMENTS

PRESENT MEDICATION

ALLERGIES (DRUGS OR OTHER)

OTHER EXPLANATIONS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE_____DATE_____

DENTIST'S SIGNATURE_____DATE_____

MEDICAL HISTORY

PATIENT'S NAME_____ ____/____/____

Last First Initial Date of Birth

1. Purpose of initial visit_____
2. Are you aware of a problem?_____
3. How long since your last dental visit?_____
4. What was done at that time?_____
5. Previous dentist's name_____
   Address:_____Tel. ( )_____
6. When was the last time your teeth were cleaned?_____

CIRCLE THE APPROPRIATE ANSWER

7. Have you made regular visits?.....YES NO
8. Were dental x-rays taken?.....YES NO
9. Have you lost any teeth or have any teeth been removed?.....YES NO
   Why?_____
10. Have they been replaced?.....YES NO
11. How have they been replaced?
    a. Fixed bridge_____Age_____
    b. Removable bridge_____Age_____
    c. Denture_____Age_____
12. Are you happy with the replacement?.....YES NO
    If no, explain_____
13. Would you like to know about permanent replacements?.....YES NO
14. Have you ever had any problems or complications with previous dental treatment?.....YES NO
    If yes, explain_____
15. Do you clench or grind your teeth?.....YES NO
16. Does your jaw click or pop?.....YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? YES NO
18. Do you have frequent headaches, neckaches or shoulder aches?.....YES NO
19. Does food get caught between your teeth?.....YES NO
20. Are any of your teeth sensitive to hot_____ cold_____ sweets_____pressure_____
21. Do your gums bleed or hurt?.....YES NO
    When?_____
22. How often do you brush your teeth?_____When_____
23. Do you use dental floss?.....YES NO
24. Are any of your teeth loose, tipped or shifted?.....YES NO
25. Are you happy with the appearance of your teeth; do you have any discolored teeth that bother you?.....YES NO
26. How do you feel about your teeth in general?_____
27. Do you feel your breath is offensive at times?.....YES NO
28. Have you ever had gum treatment or surgery?.....YES NO
    What_____
    Where_____
    When_____
29. Have you had any orthodontic work?.....YES NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?_____
31. Do you have any questions or concerns?.....YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE_____DATE_____

DENTIST'S SIGNATURE_____DATE_____

DENTAL HISTORY