

MEDICAL HISTORY

NAME: _____

1. Have you been under the care of a physician during the past two years? **YES NO**
 If yes, for what? _____

Physician's Name: _____ Phone: _____

2. Have you taken any medication or drugs during the past two years? **YES NO**

3. Are you taking any medication, drugs or pills now? **YES NO**

If yes, what? _____

4. Are you aware of having an allergic (or adverse) reaction to any medication or substance such as antibiotics or anesthesia? **YES NO**

If yes, please explain. _____

5. Have you been a patient in the hospital during the past five years? **YES NO**

6. Have you lost or gained more than ten pounds in the past year? **YES NO**

7. **WOMEN.** Are you: **Pregnant?** Yes, ___ Months **No NURSING?** YES NO

Taking birth control pills? YES NO

8. Please indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	YES NO	Ulcers	YES NO
Chest Pain	YES NO	Diabetes	YES NO
Heart Murmur	YES NO	Thyroid Problems	YES NO
High Blood Pressure	YES NO	Glaucoma	YES NO
Mitral Valve Prolapse	YES NO	Contact Lenses	YES NO
Artificial Heart Valve	YES NO	Emphysema	YES NO
Heart Pacemaker	YES NO	Chronic Cough	YES NO
Rheumatic Fever	YES NO	Tuberculosis	YES NO
Arthritis/Rheumatism	YES NO	Asthma	YES NO
Cortisone Medicine	YES NO	Hay Fever	YES NO
Swollen Ankles	YES NO	Latex Sensitivity	YES NO
Stroke	YES NO	Radiation Therapy	YES NO
Diet (Special/Restricted)	YES NO	Chemotherapy	YES NO
Artificial Joints (hip, knee, etc.)	YES NO	Tumors, Malignancies	YES NO
Kidney Trouble	YES NO	Anemia	YES NO
Ear/Sinus Infection	YES NO	Venereal Disease	YES NO
Hepatitis A (Infectious)	YES NO	AIDS	YES NO
Hepatitis B (Serum)	YES NO	H.I.V. Positive	YES NO
Cold Sores	YES NO	Blood Transfusion	YES NO
Fever Blisters	YES NO	Hemophilia	YES NO
Liver Disease	YES NO	Bruise Easily	YES NO
Yellow Jaundice	YES NO	Bleeding Tendency	YES NO
Sickle Cell Disease	YES NO	Epilepsy or Seizures	YES NO
Neurological Disorder	YES NO	Nervous/Anxious	YES NO
Fainting or Dizzy Spells	YES NO	Chicken Pox	YES NO
Scarlet Fever	YES NO	Psychiatric/Psychological Care	YES NO
I.V. Drug Use	YES NO		

9. Do you have any disease, condition or problem not listed? **YES NO**

If yes, please list: _____

All information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

DENTAL HISTORY

NAME: _____
 What is the reason for your visit today? _____
 Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____
 What was done at your last dental visit? _____
 Previous Dentist's Name: _____ Phone: _____
 Address: _____ State: _____ Zip: _____
 How often do you have dental exams? _____
 How often do you brush your teeth? _____ How often do you floss? _____
 What dental aids do you use?(interplak, toothpick, etc..) _____
 Do you have any dental problems now? **YES NO**
 If yes, please describe: _____

Do you wear dentures? **YES NO**
 Are you unhappy with your dentures? **YES NO**
 Would you like to know more about permanent replacements? **YES NO**

Are your teeth sensitive to:

Hot or cold?	YES NO	Have you experienced:	
Sweets?	YES NO	Clicking or popping of the jaw?	YES NO
Biting or chewing?	YES NO	Limited mouth opening?	YES NO
Have you noticed:		Pain? (Jaw joint, ear, side of face?)	YES NO
Mouth odor?	YES NO	Difficulty in chewing on either side of the mouth?	YES NO
Bad tastes?	YES NO	Headaches?	YES NO
Do you frequently get:		Neckaches?	YES NO
Cold sores?	YES NO	Sore muscles? (neck or shoulders?)	YES NO
Fever blisters or oral lesions?	YES NO	Are you satisfied with your teeth's appearance?	YES NO
Do your gums hurt or bleed?	YES NO	Would you like to improve your teeth's appearance?	YES NO
Have your parents had gum disease or tooth loss?	YES NO	Would you like to keep all of your teeth all of your life?	YES NO
Have you noticed any loose teeth or change in your bite?	YES NO	Do you have any discolored, misaligned or missing teeth?	YES NO
If yes, where? _____		Do you have any spaces between your teeth?	YES NO
Do you have a history of:		Do you feel nervous about having dental treatment?	YES NO
Clenching or grinding your teeth while asleep or awake?	YES NO	Have you ever had an upsetting dental experience?	YES NO
Biting your lips or cheeks regularly?	YES NO	If yes, please describe _____	
Holding foreign objects with your teeth? (pencils, pipe, etc.)	YES NO	_____	
Biting fingernails?	YES NO	_____	
Mouth breathe while asleep or awake?	YES NO	Is there anything about your mouth, teeth, or existing dental work that you are unhappy with? If so, what? _____	YES NO
Have tired jaws especially in the morning?	YES NO	_____	
Smoke/chew tobacco?	YES NO	_____	
How much? _____		_____	
Do you drink more than one alcoholic beverage per day?	YES NO	Have you been satisfied with previous dental treatment? If not, why? _____	YES NO
How much? _____		_____	
Have you ever had:		_____	
Orthodontic treatment?	YES NO	Have you had a serious injury to the mouth or head? If so, please describe, including cause. _____	YES NO
Fluoride treatment?	YES NO	_____	
Oral surgery?	YES NO	_____	
Periodontal treatment?	YES NO	_____	
Your teeth ground or bite adjusted?	YES NO	_____	
A bite plate or mouth guard?	YES NO	_____	
Root canal?	YES NO	_____	
T.M.J. treatment?	YES NO	_____	

All information is complete and accurate to the best of my knowledge.

Signature: _____ **Date:** _____