

YOUR NAME: _____
 Physician's Name: _____
 When was your last visit to your physician? _____
 When was your last complete physical? _____

Today's Date: _____
 Physician's Phone #: _____

MEDICAL History

Please tell us if you have had any of the following by checking the appropriate box(es):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Bacterial Endocarditis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Any artificial replacement | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Artificial Knee, Hip, Joint | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Pins, Plate | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia / Blood Problems | <input type="checkbox"/> Rheumatism / Arthritis | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic Heart Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valve(s) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Ulcer / Colitis |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart Attack _____ Year | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Eye Disorders / Glaucoma | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Pregnant _____ Months |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancers, Tumors, Growths | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Immunosuppressive | <input type="checkbox"/> Radiation Treatments | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Disorders / ARC | | |

Please list any ALLERGIES to Drugs, Medications or Anesthetics: _____

Please list any other MEDICAL CONDITIONS not mentioned above: _____

Please list all DRUGS/MEDICATIONS you currently take:
 (Include the dose and frequency that you are on) _____

DENTAL History

Please describe your chief oral complaint: _____

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| Are your teeth sensitive to: | | | Have you had a complete dental examination, | | |
| Heat? | <input type="checkbox"/> | <input type="checkbox"/> | Including full mouth X-rays in the last 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold? | <input type="checkbox"/> | <input type="checkbox"/> | Have you had your teeth cleaned regularly? | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweets? | <input type="checkbox"/> | <input type="checkbox"/> | When was your last cleaning? _____ | | |
| Chewing? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have all or most of your natural teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any food traps? | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to keep your natural teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums ever feel tender or swollen? | <input type="checkbox"/> | <input type="checkbox"/> | If you had teeth removed, were they replaced? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums bleed when brushing? | <input type="checkbox"/> | <input type="checkbox"/> | Do you like the appearance of your smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any teeth that feel loose? | <input type="checkbox"/> | <input type="checkbox"/> | If you could improve your teeth or smile, what would you do? | | |
| Have you ever been treated for periodontal disease? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Do you use dental floss? | <input type="checkbox"/> | <input type="checkbox"/> | Do you consider yourself a nervous patient? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any previous injuries to your face or jaws? | <input type="checkbox"/> | <input type="checkbox"/> | Ever had an unpleasant dental experience? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you lose or break fillings? | <input type="checkbox"/> | <input type="checkbox"/> | When was your last dental appointment? _____ | | |
| Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | What was done at that visit? _____ | | |
| Do you strike some teeth before others when closing? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Have you ever had your bite adjusted? | <input type="checkbox"/> | <input type="checkbox"/> | Where was it done? _____ | | |
| Do your jaws ever ache or feel tired? | <input type="checkbox"/> | <input type="checkbox"/> | Ever experienced problems with Novocain? | <input type="checkbox"/> | <input type="checkbox"/> |