MEDICAL HISTORY

General health (please check): Excellent☐ Good☐ Fair☐ Poor☐

Name and address of physician _____

Last complete physical? _____

Are you taking any medication now? Yes☐ No☐ Vitamins / Supplements? _____

Names of medications: _____

Have you ever been diagnosed or treated for:

Heart Disease ..... Yes☐ No☐
Rheumatic Fever ..... Yes☐ No☐
Abnormal Blood Pressure ..... Yes☐ No☐
Ulcers ..... Yes☐ No☐
Tuberculosis / Cough ..... Yes☐ No☐
Diabetes ..... Yes☐ No☐
Epilepsy / Seizures ..... Yes☐ No☐
Anemia ..... Yes☐ No☐
Congenital Heart Lesions ..... Yes☐ No☐
VD (Syphilis, Gonorrhea, Herpes) ..... Yes☐ No☐
HIV Virus / AIDS ..... Yes☐ No☐
Prosthetic Hip or Knee ..... Yes☐ No☐

Depression ..... Yes☐ No☐
Heart Murmur / MVP / Artificial Valve ..... Yes☐ No☐
Jaundice / Liver Dysfunction ..... Yes☐ No☐
Asthma or Hay Fever ..... Yes☐ No☐
Sinus Trouble ..... Yes☐ No☐
Thyroid Problem ..... Yes☐ No☐
Hepatitis / A / B / C ..... Yes☐ No☐
Arthritis ..... Yes☐ No☐
Stroke ..... Yes☐ No☐
Glaucoma ..... Yes☐ No☐
Serious Accident ..... Yes☐ No☐
Kidney Problem ..... Yes☐ No☐
Organ Transplant ..... Yes☐ No☐

Have you ever been treated (other than diagnostic) with x-ray? ... Yes☐ No☐ Do you take antibiotics before dental appointments?... Yes☐ No☐

Are you allergic to: Penicillin☐ Codeine☐ Local injected anesthetics☐ Latex☐ Sulfa☐ Other medications☐ _____

Are you subject to prolonged bleeding? ..... Yes☐ No☐
Are you subject to fainting spells? ..... Yes☐ No☐
(Women) Are you pregnant? ..... Yes☐ No☐ How Long? _____

DENTAL HISTORY

Date of last dental visit? _____ Dentist's Name _____ Phone _____

Did you have x-rays taken? ..... Yes☐ No☐
Have you had all your teeth x-rayed in the past 3 years? ..... Yes☐ No☐
Do you wear full or partial dentures? ..... Yes☐ No☐ (If Yes) How old are they? _____
Does any member of your family, including your parents, wear dentures? ..... Yes☐ No☐
Are you dissatisfied with the appearance of your teeth? ..... Yes☐ No☐
Have you had orthodontic treatment? ..... Yes☐ No☐
Do you clench or grind your teeth during the day or night? ..... Yes☐ No☐
Have you ever had pain in your jaw joint or your face (In and about your ears)? ..... Yes☐ No☐
Does your jaw joint click? ..... Yes☐ No☐ Do you have difficulty opening your mouth widely? ..... Yes☐ No☐
Do you have an unpleasant odor, or taste, in your mouth? ..... Yes☐ No☐
Do your gums bleed when brushing? ..... Yes☐ No☐ Have you had gum disease or pyorrhea? ..... Yes☐ No☐
Is your mouth or teeth sensitive to: Pressure ..... Yes☐ No☐ Cold ..... Yes☐ No☐ Hot ..... Yes☐ No☐
Does food catch between your teeth? ..... Yes☐ No☐
How often do you: Brush? _____ Floss? _____

Please add anything you feel is important for the doctor to know _____

Patient's Signature _____

DATE	SERVICES	CHARGES	CREDITS	BALANCE

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