DENTAL HISTORY

Do you have a specific dental problem? YES NO

Do you want to keep your teeth? YES NO

Do you have dental exams regularly? YES NO

Do you like your smile? YES NO

Do your gums ever bleed? YES NO

Do you grind your teeth at night? YES NO

Do you have joint noise or pain? YES NO

Do you have frequent headaches? YES NO

Do you feel nervous about dental treatment? YES NO Date of last dental examination_____

MEDICAL HISTORY

Medical Doctor's Name_____Phone_____Last of last physical exam_____

How is your general state of health? Good___ Fair___ Poor___ Do you require antibiotic prior to treatment_____

Are you presently under a physician's care? YES NO Describe_____

Have you had any serious illness? ____ If so, what_____

Have you been hospitalized in the last two years? YES NO Why?_____

Women: Are you pregnant? YES NO How many months?_____

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

PLEASE MARK IF NONE:

ALLERGIES

Local Anesthetic (Novacaine) Sulfa

Asprin Milk Penicillin

Codine Iodine Latex

Other_____

PLEASE MARK IF NONE:

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

___Heart Trouble	___Chest Pains	___Scarlet Fever	___High Blood Pressure
___Shortness of Breath	___Asthma	___Sinus Trouble	___Low Blood Pressure
___Swelling of Feet etc.	___Heart Murmur	___Fainting, Dizziness	___Emphysema
___Rheumatic Fever	___Stroke	___Frequent Cough	___Artificial Valve
___Artificial Joints	___Lung Disease	___Heart Pacemaker	___Diabetes
___Blood Disease	___Tuberculosis	___Heart Surgery	___Kidney Disease
___Liver Disease	___Ulcers	___Thyroid Disease	___Hepatitis A
___Anemia	___Cancer	___Allergies	___Hepatitis B
___Parathyroid Disease	___Chemo/Radiation	___Yellow Jaundice	___Hepatitis C
___Arthritis/Gout	___Rheumatism	___Epilepsy/Seizures	___Cortisone Meds
___Glaucoma	___Blood Transfusion	___Nervousness	___Hypoglycemia
___Drug Addiction	___Psychiatric Care	___Alcohol Addiction	___Hemophilia
___AIDS/HIV	___Venereal Disease	___Cold Sores	___Herpes
___Bruise Easily	___Sickle Cell Anemia		

PLEASE MARK IF NONE

PATIENT SIGNATURE _____DATE_____

DOCTOR SIGNATURE_____DATE_____

Update_____Update_____Update_____Update_____Update_____Update_____