

MEDICAL HISTORY

1. Are you in good health? yes no Date of Last Physical Examination? _____
2. Are you now under the care of a physician? If so, why? _____ yes no
3. Physicians name and address: _____
4. Have you ever had a serious illness or operation? If so, what? _____ yes no
5. Have you ever been hospitalized? If so why? _____ yes no
6. Do you have chest pain upon exertion? _____ yes no
7. Are you ever short of breath upon mild exercise? _____ yes no
8. Do your ankles swell? _____ yes no
9. Are you taking blood thinners / Coumadin _____ yes no
10. Do you wear a cardiac pacemaker? _____ yes no
11. Have you ever had heart surgery? _____ yes no
12. Have you had a joint replacement?, If yes what? _____ yes no
13. Are you taking any drugs or medications? _____ yes no

List Medications and reason for taking them: _____

14. Are you allergic or have you reacted adversely to any of the following medications: (Please check if yes)

- | | | | |
|---------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Percodan | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Valium | <input type="checkbox"/> Novacaine |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Xylocaine |

15. Have you ever had: (please check if yes)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> AIDS or ARC |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hives or Skin Rash | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting or Seizures | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Mitrovalve Prolapse | <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaundice/Liver Disease | <input type="checkbox"/> Difficulty in Swallowing | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Transfusion | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> AIDS (Acquired Immune Deficiency Syndrome) | |

16. Do you smoke, chew tobacco, or use any tobacco product? If yes, what and how much _____ yes no
17. Do you use any alcohol products? If yes, how much? _____ yes no
18. (Women) Are you pregnant? If yes, how many months? _____ yes no
19. (Women) Are you taking birth control? If so, what? _____ yes no

DENTAL HISTORY

1. Please describe the reason for your appointment today: _____
2. Are you in discomfort at this time? _____ yes no
3. Have you ever had a serious problem associated with previous dental treatment? _____ yes no
If yes, please explain: _____
4. Do you have, or have you had any of the following?

<input type="checkbox"/> Pain in jaw (TMJ)	<input type="checkbox"/> Bleeding sore gums	<input type="checkbox"/> Orthodontics (braces)	<input type="checkbox"/> Sensitive to hot
<input type="checkbox"/> Clicking / popping jaw	<input type="checkbox"/> Burning tongue / lips	<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Sensitive to cold
<input type="checkbox"/> Difficulty opening jaw	<input type="checkbox"/> Bad taste / breath	<input type="checkbox"/> Clenching or grinding	<input type="checkbox"/> Sensitive to sweet
<input type="checkbox"/> Difficulty closing jaw	<input type="checkbox"/> Blisters on lips or mouth	<input type="checkbox"/> Periodontal (gum) disease	<input type="checkbox"/> Sensitive to biting
5. Does dental treatment make you nervous? No Slightly Moderately Extremely
6. How do you routinely care for your teeth? Brush Floss Water-Pik Fluoride rinse/gel Other
7. How long has it been since your last full mouth x-rays? _____
8. Previous Dentist: _____ Date of last visit: _____
Phone number: _____ City, State: _____
9. Are you happy with your smile? _____ yes no
10. Would you like your teeth to be whiter? _____ yes no

Signature of Patient _____

Date _____

Signature of Dentist _____

Date _____