PLEASE PRINT

NAME	SEX M ☐ F ☐	BIRTHDATE	MARITAL STATUS	DATE OF RECORD

WHOM MAY WE THANK FOR REFERRING YOU

PRESENT DENTAL COMPLAINT

PHYSICIAN	ADDRESS	CITY	STATE	ZIP	TELEPHONE
DENTIST	ADDRESS	CITY	STATE	ZIP	TELEPHONE

MEDICAL AND DENTAL HISTORY

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health? ..... YES NO

Has there been any change in your general health within the past year? ..... YES NO

My last physical examination was on _____

Are you now under the care of a physician(s)? ..... YES NO

If so, what is the condition being treated? _____

Are you taking any medication(s) now? (Example: bloodthinner, tranquilizers, heart medication) .... YES NO

If so, what medication(s) are you taking _____

Have you had any serious illness, operation, or been hospitalized? ..... YES NO

If so, what was the illness or problem? _____

HAVE YOU EVER HAD:

Hepatitis or Liver Disease	YES	NO
Sexually Transmitted Disease	YES	NO
AIDS or HIV Infection	YES	NO
Epilepsy	YES	NO
Rheumatic Fever	YES	NO
Heart Trouble	YES	NO
Heart Murmur	YES	NO
Chest Pains	YES	NO
High/Low Blood Pressure	YES	NO
Respiratory Problems	YES	NO
Shortness of Breath	YES	NO
Asthma or Hayfever	YES	NO
Sinus Problems	YES	NO
Allergies	YES	NO
Tuberculosis	YES	NO
Persistent Cough	YES	NO
Persistent Swollen Glands in Neck	YES	NO
Thyroid Problems	YES	NO
KidneyDisease	YES	NO
Ulcer	YES	NO
Prostate Trouble	YES	NO
Diabetes	YES	NO
Glaucoma	YES	NO
Burning Tongue	YES	NO
Contact Lenses	YES	NO
Arthritis	YES	NO
Fainting Spells or Seizures	YES	NO
Persistent Diarrhea	YES	NO
Cancer	YES	NO
Problems of the Immune System	YES	NO
Medical Treatment by X-Ray	YES	NO
Psychiatric Treatment	YES	NO
Abnormal Bleeding	YES	NO
Anemia	YES	NO
Treatment for a Tumor or Growth	YES	NO
Drug Reaction	YES	NO

WOMEN:

Are you pregnant?	YES	NO
Are you nursing?	YES	NO
Are you taking birth control pills?	YES	NO

ALLERGIES:

Are you allergic or have you had a reaction to:		
Local anesthetics	YES	NO
Penicillin, tetracycline, erythromycin, sulfa drugs or other antibiotics	YES	NO
Valium, barbiturates, sedatives, or sleeping pills	YES	NO
Aspirin or acetaminophen	YES	NO
Corticosteroids or Phenergan	YES	NO
Codeine, Demerol or other narcotics	YES	NO

Other _____

_____

ARE YOU:

Allergic to dental anesthetic	YES	NO
Subject to frequent headaches	YES	NO
Slow in healing	YES	NO
Aware of grinding or clenching your teeth day or night	YES	NO
Satisfied with appearance of your teeth	YES	NO
Wearing removable dental appliance	YES	NO

DO YOU:

Ever have sore teeth	YES	NO
Have bleeding gums	YES	NO
Have bad breath	YES	NO
Have tooth sensitivity	YES	NO
To Heat	YES	NO
To Cold	YES	NO
To Sweets	YES	NO
Use Dental Floss	YES	NO
Have a fear of dental treatment	YES	NO
Have prolonged bleeding after injury or tooth extraction	YES	NO
Have sore or popping jaw	YES	NO

HAVE YOU:

Ever been told you have gum trouble	YES	NO
Ever had trench mouth	YES	NO
Ever been treated for Periodontal disease (Pyorrhea)	YES	NO
Ever had orthodontic treatment	YES	NO
Had shifting of any teeth	YES	NO

Any serious illness not listed: _____

_____

_____

Have you had any serious trouble associated with any previous dental treatment? _____

If so, explain _____

_____

_____

_____

_____