

**YOUR NAME:** \_\_\_\_\_

Today's Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_

When was your last visit to your physician? \_\_\_\_\_

When was your last complete physical? \_\_\_\_\_

## 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"/> |