NAME: ____________________ BIRTH DATE: ____________

MEDICAL HISTORY

Do you now have or ever had any of the following: Please circle Yes or No

Condition		
Heart Murmur	Y	N
Rheumatic Fever	Y	N
Pace Maker	Y	N
Prosthetic Heart Valve	Y	N
Stroke	Y	N
Heart Conditioner	Y	N
Hepatitis	Y	N
Jaundice	Y	N
Tuberculosis	Y	N
Venereal Disease	Y	N
Syphilis	Y	N
Epilepsy	Y	N
Diabetes	Y	N
High Blood Pressure	Y	N
Sickle Cell Anemia	Y	N
Low Iron Anemia	Y	N
Bleeding Problems	Y	N
Kidney Disease	Y	N
Asthma	Y	N
Radiation or Cobalt Treatment	Y	N
AIDS Exposure	Y	N
Glaucoma	Y	N
Ulcer	Y	N
Prosthetic Joint Replacement	Y	N

Are you allergic to:

Penicillin	Y	N
Aspirin	Y	N
Codeine	Y	N
Local Anesthetic	Y	N

Others: ____________

Are you taking any:

Blood Thinners	Y	N
Tranquilizers	Y	N
Amphetamines	Y	N

Others: ____________

Women: Are you pregnant? Y N

If yes, month due: ____________

Name of Physician: ____________

Phone Number: ____________

Please describe any current medical treatments, impending operations or dental information the doctor should know about: ____________

____

____

DENTAL HISTORY

Date of last dental visit ____________ Were X-rays taken ? Y N

Name of last dentist ____________ Phone # ____________

What work was done? ____________

How often do you brush? ____________ Floss? ____________

Please answer the following by circling Yes or No:

Question		
Do your gum bleed when you brush?	Y	N
Have you ever had periodontal treatment?	Y	N
Do you clench, grind or brux (gnash) you teeth?	Y	N
Do you have frequent headaches, neck or shoulder pain?	Y	N
Are your teeth sensitive to hot, cold or sweets?	Y	N
Have you ever had complications following an extraction?	Y	N
Have you ever had a reaction to dental treatment?	Y	N
Are you satisfied with the appearance of your teeth?	Y	N
Do you have clicking popping or gravel-like sound in your jaw joint?	Y	N
Do your teeth or jaws ever feel "tired" or sore when you wake up?	Y	N
Do you have loose or sensitive teeth?	Y	N
Do you now, or have you ever had, pain in your jaw joint or in the sides of your face?	Y	N
Do you have frequent ear pain, ringing or stuffiness in the ears?	Y	N

I certify that I have accurately completely the above to the best of my knowledge.

Signature ____________ Date ____________