FOR OFFICE USE ONLY

Name:_____ Date of Birth:_____ Home:_____ Business:_____

Home Address:_____ Business Company/ Position:_____

Marital Status: M S Sep. D W Spouse/ Guardian Name & Address:_____

Referral Source:_____ Remarks:_____ DL:_____ Patient SSN:_____

Patient, Please Fill Out

DENTAL HISTORY

Purpose of initial visit _____

Are you aware of any particular dental problem?_____

_____

How long has it been since your last visit to a dental office?_____

What was done?_____

_____

_____

How do you feel about your teeth in general?_____

Are you pleased with the appearance of your teeth?_____

If no, please explain _____

_____

Have you ever used nitrous oxide?_____

Did you like it?_____

Are you worried about receiving dental treatment?_____

Any discomfort or pain? _____

Are your teeth sensitive? _____

To what (heat, cold, or biting pressure)?_____

Do you have any ear trouble?_____

Have you lost any teeth?_____ Why?_____

Replaced by:_____

Do you have difficulty in chewing your food?_____

Is your mouth frequently dry?_____

Do you have bad breath or taste?_____

Remedies:_____

Gums bleed?_____

Does your jaw pop or click? _____

What cleaning method do you use?_____

Do you snore? _____

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MEDICAL UPDATES:

I have read my MEDICAL HISTORY dated_____and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient's Signature	Received by
_____	_____	None ☐ _____	_____
_____	_____	None ☐ _____	_____
_____	_____	None ☐ _____	_____
_____	_____	None ☐ _____	_____
_____	_____	None ☐ _____	_____
_____	_____	None ☐ _____	_____
_____	_____	None ☐ _____	_____
_____	_____	None ☐ _____	_____
_____	_____	None ☐ _____	_____

NOTES

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HEALTH HISTORY

Personal Information: This personal information will help us to give you the most consideration of your time and feelings. It is important to have complete answers. **ALL INFORMATION, OF COURSE, IS CONFIDENTIAL.**

Medical History:

Please check **YES** or **NO** if you have had any of the following:

Heart Trouble	( )Yes ( )No	Headaches	( )Yes ( )No	Hepatitis B (serum)	( )Yes ( )No
High Blood Pressure	( )Yes ( )No	Fainting	( )Yes ( )No	Sores that do not	
Low Blood Pressure	( )Yes ( )No	Dizziness	( )Yes ( )No	heal within 1 week	( )Yes ( )No
Heart Murmur	( )Yes ( )No	Stroke	( )Yes ( )No	Recent Weight Loss	( )Yes ( )No
Rheumatic Fever	( )Yes ( )No	Diabetes	( )Yes ( )No	Cancer	( )Yes ( )No
Congenital Heart		Artificial Joints/ Hips	( )Yes ( )No	Thyroid Disease	( )Yes ( )No
Condition	( )Yes ( )No	Kidney Trouble	( )Yes ( )No	Parathyroid Disease	( )Yes ( )No
Artificial Heart		Ulcers	( )Yes ( )No	X-ray or Cobalt Tmt.	( )Yes ( )No
Valve	( )Yes ( )No	Allergies	( )Yes ( )No	Chemotherapy	( )Yes ( )No
Heart Pacemaker	( )Yes ( )No	Asthma	( )Yes ( )No	Radiation	( )Yes ( )No
Heart Surgery	( )Yes ( )No	Hay Fever	( )Yes ( )No	Arthritis/ Gout	( )Yes ( )No
Mitral Valve Prolapse	( )Yes ( )No	Sinus Trouble	( )Yes ( )No	Glaucoma	( )Yes ( )No
Blood Disease		Emphysema	( )Yes ( )No	Epilepsy or Seizures	( )Yes ( )No
(anemia, mono)	( )Yes ( )No	Frequent Cough	( )Yes ( )No	Alzheimer's Disease	( )Yes ( )No
Chest Pain	( )Yes ( )No	Lung Disease		Hypoglycemia	( )Yes ( )No
Shortness of Breath	( )Yes ( )No	(tuberculosis, etc.)	( )Yes ( )No	Psychiatric Care	( )Yes ( )No
Swelling of Feet/		Liver Disease	( )Yes ( )No	Hemophilia	( )Yes ( )No
Ankles/ Hands	( )Yes ( )No	Hepatitis A (infec.)	( )Yes ( )No	HIV Positive	( )Yes ( )No

Please list any other serious illness not listed above: _____

Women: Are you taking birth control pills? _____ Are you pregnant? _____

Please circle if you have any allergic reaction to any of the following:

Codeine **Local Anesthetics** **Iodine** **Other** _____

Penicillin **Aspirins** **Sulfonamides (sulfa)** **Barbiturates (sleeping pills)**

Have there been any problems in your general health? (Serious illness, hospitalization, surgery, regular physician visits.) _____

_____

Are you under treatment at the present time? _____ If so, please describe: _____

_____

What tablets, pills, or liquids do you take? (Include aspirin, vitamins, tonics, etc.) _____

_____

Physician's name and address _____

Comments _____

Date of your last medical check up _____ Date of last eye exam _____

Have you ever had a blood transfusion? _____ When? _____

Male or Female _____ Height _____ Weight _____ Do you smoke? _____

Do you consume more than 3 ounces of alcohol per day? (approx. 3 or more beers or drinks)

_____

I certify that the above information is true and correct to the best of my knowledge.

_____

Date Print Name Signature