MEDICAL HISTORY

Date of last physical exam _____ Reason _____

Is a medical doctor treating you now? YES/NO
Is so, for what reason? _____

Are you taking any medicine, including over the counter? YES/NO
If yes, what? _____

Are sensitive, or allergic to any medication? YES/NO
If yes, what? _____

Have you ever been hospitalized or had any surgical procedures? YES/NO
If yes, please list reasons and dates _____

Do you need to be pre-medicated for dental treatment (i.e. Heart Murmur/Artificial Joint)? YES/NO

If yes, why? _____

Do you have a history of drug or alcohol addiction? YES/NO
Please specify _____

Do you use tobacco products? YES/NO
If so, what type and how often _____

FEMALES:
Are you taking oral contraceptives? YES/NO
Are you pregnant or lactating? YES/NO Date of Delivery: _____
Are you taking hormone replacement therapy? YES/NO

DO YOU HAVE, OR HAVE YOU HAD:

__Anemia	__Head injuries	__Nervous Disorders
__Arthritis	__Heart Attack	__Pacemaker
__Artificial Joints	__Heart Murmur	__Radiation therapy
__Asthma	__Hepatitis	__Respiratory Problem
__Bleeding Disorder	__High Blood Pressure	__Rheumatic Fever
__Diabetes	__HIV/AIDS	__Sinus Problems
__Dizziness	__Kidney Disease	__Stroke
__Epilepsy	__Liver Disease	__Tuberculosis
__Fainting	__Mental Disorder	__Tumors
__Glaucoma	__Mitral Valve Prolapse	__Venereal Disease

Are you excessively nervous or depressed? YES/NO
Have you ever been treated for nervous or mental disorders? YES/NO
Do you find it necessary to sleep using two pillows at night? YES/NO
Have you recently gained or lost excessive amounts of weight? YES/NO
Have you had abnormal bleeding after a cut or tooth extraction? YES/NO

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DENTAL HISTORY:

Reason for this visit _____
Last visit to a dentist _____ what was done? _____
Date of last cleaning _____ Have you had an injury to your face or jaw? YES/NO
Have you ever had: __Periodontal treatment __Orthodontic treatment __Oral Surgery
Have you noticed any loosening of your teeth? YES/NO
Do you suffer from pain and/or swelling of your gums? YES/NO
Do your gums often bleed when you brush your teeth? YES/NO
Do you have an unpleasant odor or taste in your mouth? YES/NO
How often do you brush your teeth? _____ __Electric toothbrush __Hand toothbrush
What else do you use to clean your teeth? __Floss __Toothpick __WaterPik
Do you feel apprehensive when you have dental treatment? YES/NO
Would you like to use Nitrous Oxide (Laughing Gas) in conjunction with treatment? YES/NO
Does the fear of pain make you postpone dental treatment? YES/NO
Is it important for you to keep your teeth? YES/NO