Medical History

Do you have a physician? Yes No
Their name: _____
Their phone: _____
Date of last doctor's appt: _____
Your current physical health is:
Good Fair Poor
Are you currently under the care of any physician?
Yes No
If yes, please explain: _____
_____
_____
Do you smoke or use tobacco in any form?
Yes No
Are you presently taking any drugs prescribed by a physician or dentist? Yes No
If yes, please list: _____
For women: Are you pregnant?
No Yes Week #: _____
Have you had any serious medical problems in the last 5 years? No Yes
If yes, please explain: _____
_____
_____

Have you ever had any of the following diseases or medical problems?

Y	N	Heart Attack / Stroke
Y	N	Heart Murmur / Rheumatic Fever
Y	N	Heart Surgery / Pacemaker
Y	N	Chronic Hepatitis
Y	N	Anemia
Y	N	High / Low Blood Pressure
Y	N	Severe Headaches
Y	N	Epilepsy / Seizures / Fainting
Y	N	Drug / Alcohol Abuse
Y	N	Hemophilia / Abnormal Bleeding
Y	N	Cancer / Chemotherapy
Y	N	HIV + / Aids
Y	N	Shingles
Y	N	Kidney Problems
Y	N	Sinus Problems
Y	N	Fever Blisters
Y	N	Psychiatric Problems
Y	N	Diabetes
Y	N	Tuberculosis
Y	N	Sickle Cell Disease

Are you allergic to any of the following? Penicillin Tetracycline Aspirin Codeine Erythromycin Dental Anesthetic

Please list any other drugs you are allergic to: _____

Dental History

Why have you come to the dentist today? _____

Do you want to save your teeth?	Yes	No
Are you having any dental pain now?	Yes	No
Do you have any pain from hot, cold, or sweets?	Yes	No
Are any teeth tender to touch or percussions?	Yes	No
Do you have any pain when you bite or chew?	Yes	No
Do your jaws click / make noise when you yawn or open wide?	Yes	No
Do you grind or clench your teeth?	Yes	No
Have you ever had orthodontics?	Yes	No
Do you chew on both sides of your mouth?	Yes	No
Do your gums bleed?	Yes	No

How often do you brush? _____ Vigorously / Lightly

What kind of brush do you use? Hard Medium Soft

Do you do anything else for your oral hygiene?	Yes	No

If yes, what else? _____

Have you ever had professional instruction in home care?	Yes	No

When was your last dental visit? _____

What was done at that time? _____