



## MEDICAL HEALTH

Name and address of physician \_\_\_\_\_

Have you been under a physician's care during the past 2 years? \_\_\_ For: \_\_\_\_\_

Have you been treated in a hospital in the past 2 years? \_\_\_ For: \_\_\_\_\_

Have you ever had surgery? \_\_\_\_\_

If female: Are you taking hormones or birth control? \_\_\_ Are you pregnant or nursing? \_\_\_

Have you ever had a blood test for hepatitis? \_\_\_ Were you vaccinated? \_\_\_\_\_

Have you had cankers or cold sores on your lips, tongue, gums, or body? \_\_\_\_\_

Are you now taking or have you taken any prescription drugs during the past year? \_\_\_

For: \_\_\_\_\_

Are you allergic to: ( ) Penicillin ( ) Codeine ( ) Local anesthesia ( ) Other \_\_\_\_\_

Have you had or do you now have:

	Yes	No		Yes	No
Abnormal blood pressure	( )	( )	Hepatitis	( )	( )
AIDS / HIV Positive	( )	( )	Herpes	( )	( )
Allergies	( )	( )	Jaundice	( )	( )
Anemia	( )	( )	Kidney disease	( )	( )
Angina	( )	( )	Liver disease	( )	( )
Arthritis	( )	( )	Organ transplant	( )	( )
Artificial heart valves	( )	( )	Pacemaker	( )	( )
Artificial joints	( )	( )	Polio	( )	( )
Asthma	( )	( )	Prolonged bleeding	( )	( )
Cancer	( )	( )	Prolonged cough	( )	( )
Chemotherapy	( )	( )	Psychiatric treatment	( )	( )
Congenital heart lesions	( )	( )	Radiation therapy	( )	( )
Diabetes	( )	( )	Rheumatic fever	( )	( )
Drug dependency	( )	( )	Sickle cell anemia	( )	( )
Epilepsy	( )	( )	Stroke	( )	( )
Fainting	( )	( )	Thyroid disease	( )	( )
Glaucoma	( )	( )	Tuberculosis	( )	( )
Heart disease	( )	( )	Ulcers	( )	( )
Heart murmur	( )	( )	Venereal disease	( )	( )

Have you any disease, condition, or problem not previously listed? \_\_\_\_\_

## DENTAL HEALTH

When was your last dental visit? \_\_\_\_\_

Are you having any dental problems that require immediate attention? \_\_\_\_\_

Do any of the following cause tooth discomfort? Hot \_\_\_ Cold \_\_\_ Sweets \_\_\_ Chewing \_\_\_

Do you have any of the following problems:

	Yes	No		Yes	No
Gums bleed while cleansing	( )	( )	Gums feel tender or swollen	( )	( )
Clinch or grind your teeth	( )	( )	Chew on both sides of mouth	( )	( )
Jaws feel tired or ache	( )	( )	Jaws click or pop	( )	( )
Frequent headaches	( )	( )	Earaches	( )	( )
Frequent cavities	( )	( )	Any loose teeth	( )	( )
Cracked or broken teeth	( )	( )	Any wear on teeth	( )	( )
Food traps	( )	( )	Missing teeth	( )	( )

Have you had peridontal treatment? \_\_\_ When: \_\_\_\_\_

Have you had orthodontic treatment (braces)? \_\_\_ When: \_\_\_\_\_

Have any missing teeth been replaced? \_\_\_

If so, how: ( ) Fixed bridge ( ) Removable ( ) Full denture ( ) Dental implant

Are you comfortable with the replacement? \_\_\_ Please describe \_\_\_\_\_

Do you like your smile? \_\_\_ Have you had cosmetic dentistry? \_\_\_ If yes, are you pleased

with the result? \_\_\_ Please describe \_\_\_\_\_

Have you ever had an unpleasant dental experience? \_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_