MEDICAL HISTORY

1. Are you under medical treatment now? _____ Y N
2. Are you currently taking drugs or medication? List drug and condition for which you take it. _____ Y N
   Attach additional sheet if necessary. _____
3. Do you have any drug allergies? List drugs and reaction. _____ Y N
4. Do you smoke or use tobacco products? How long? _____ Quit date _____ Y N
5. Have you ever been hospitalized? Explain. _____ Y N
6. Have you ever had abnormal bleeding problems after a cut or tooth extraction? _____ Y N
7. Indicate which of the following you have had or have at the present:

heart murmur…… Y N
rheumatic fever……....Y N
artificial heart valve……...Y N
artificial joint (knee/hip)…Y N
heart disease or attack……Y N
angina…….Y N
high blood pressure……Y N
congenital heart lesions.….Y N
heart surgery……..Y N
anemia……Y N
stroke……..Y N

kidney trouble…… Y N
emphysema…….Y N
asthma……Y N
sinus trouble……...Y N
diabetes……...Y N
thyroid disease……Y N
cancer……Y N
chemotherapy…….Y N
cobalt treatment….Y N
arthritis……...Y N

HIV/ AIDS……Y N
hepatitis……...…..Y N
liver disease……..…....Y N
blood transfusion……...Y N
drug addiction…..……...Y N
hemophilia…….....Y N
venereal disease...……..Y N
epilepsy, seizures…...…Y N
fainting, dizziness…....Y N
psychological or
psychiatric treatment….Y N

WOMEN: Are you pregnant? Y N If so, which trimester? 1 2 3

DENTAL HISTORY

1. Please state briefly the reason for your visit_____
2. Do you have discomfort in your mouth now?.....Y N
3. Do you have any swelling in your mouth?.....Y N
4. Do you have any sore spots, ulcerations or growths in your mouth?.....Y N
5. Are your teeth sensitive to hot, cold or sweets?.....Y N
6. Are any of your teeth loose?.....Y N
7. Do your gums bleed, or do they feel irritated?.....Y N
8. Do you have an unpleasant taste in your mouth?.....Y N
9. Do you have pain in your jaw joint?.....Y N
10. Do you grind or clench your teeth?.....Y N
11. Does your jaw click with opening or closing?.....Y N
12. Have you ever had teeth extracted?.....Y N
13. Have you ever had a root canal?.....Y N
14. Have you ever had gum treatments?.....Y N
15. Have you ever worn braces?.....Y N
16. Do you wear dentures or plates?.....Y N
17. What type of toothbrush do you use? Hard Soft
18. Do you floss? Y N How often? _____
19. How long has it been since your last dental visit? _____
20. What was the reason for your last dental visit? _____
21. Are you nervous to receive dental treatments? not at all_____ moderate____ very_____
22. Have you had any problems receiving dental care? _____
23. Is there anything that you could tell us that would benefit us in treating your dental needs?
    _____.

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

In case of an emergency, I authorize the doctor to perform treatments and administer medications and to employ assistance as she deems necessary.

Signature _____ Date _____