

Patient Name _____ Last _____ First _____ M.I. _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	N/A	Details
Are you under a physician's care now?				
Have you ever been hospitalized or had a major operation?				
Have you had a serious head or neck injury?				
Are you taking medications, pills or drugs?				
Do you take, or have you taken, Phen-Fen or Redux?				
Are you on a special diet?				
Do you use tobacco?				
Do you use controlled substances?				

Women

Are you pregnant/Trying to get pregnant? Yes No

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

Do you have, or have you had, any of the following conditions?

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal
<input type="checkbox"/> Artificial Heart Valve*	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Pace Maker*	<input type="checkbox"/> Mitral Valve Prolapse*	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint*	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Herpes	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever*	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice
				<input type="checkbox"/> Osteoporosis

Have you ever had a serious illness not listed above? Yes No N/A _____

* Condition may require medication N/A- Not answered by patient

Comments _____

Dental History Place a mark on "yes" or "no" to indicate if you have had any of the following or are concerned about:

Bad Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums Swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No	
Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian _____ Date _____