Last Name	First Name	Single	Married	Divorced	Separated	Widowed

Name of Spouse or Guardian	Home Phone	Your Social Security No.

Residence Address	City	State	Zip

Employed By	City	State	Business Phone

Present Position	How Long Held

Spouse Employed By	City	State	Phone

Present Position	How Long Held

Referred By	Address

Physician's Name	Address

Birthdate	Age	Cell Phone

Person Responsible for Account

It is important that I know your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.

If your answer is YES to the question, put a circle around "YES"
If your answer is NO to the question, put a circle around "NO."
Please answer all of the questions. Thank you.

1. Are you in good health? .... YES NO
   a. Has there been any change in your general health within the past year? .... YES NO
2. My last physical examination was on ____________
   My last dental examination was on ____________
3. Are you now under the care of a physician? .... YES NO
   a. If so, what is the condition being treated? ____________
4. Have you had any serious illness or operation? .... YES NO
   a. If so, what was the illness or operation? ____________
5. Have you been hospitalized or had a serious illness within the past 5 years? .... YES NO
   a. If so, what was the problem? ____________
6. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease .... YES NO
   b. Congenital heart lesions .... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, stroke, arteriosclerosis) .... YES NO
   d. Allergy .... YES NO
   e. Asthma or hay fever .... YES NO
   f. Sinus trouble .... YES NO
   g. Hives or skin rash .... YES NO
   h. Fainting spells or seizures .... YES NO
   i. Diabetes .... YES NO
      1) Do you have to urinate (pass water) more than six times a day? .... YES NO
      2) Are you thirsty much of the time? .... YES NO
      3) Does your mouth frequently become dry? .... YES NO
   j. Hepatitis; jaundice or liver disease .... YES NO
   k. Arthritis .... YES NO
      Inflammatory rheumatism (painful, swollen joints) .... YES NO
   m. Stomach ulcers .... YES NO
   (over)

n. Kidney trouble .... YES NO
o. Tuberculosis .... YES NO
p. Do you have a persistent cough or cough up blood? .... YES NO
q. Low blood pressure .... YES NO
r. Venereal disease .... YES NO
s. Other ____________

7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? .... YES NO
   a. Do you bruise easily? .... YES NO
   b. Have you ever required a blood transfusion? .... YES NO
   If so, explain the circumstances ____________
   ____

8. Do you have any blood disorder such as anemia? ... YES NO
9. Have you had surgery or x-ray therapy for a tumor, growth, or any other condition of your mouth or lips? .... YES NO
10. Are you taking any drug or medicine? .... YES NO
   If so, what? ____________
11. Are you taking any of the following:
   a. Antibiotic or sulfa drugs .... YES NO
   b. Anticoagulants (blood thinners) .... YES NO
   c. Medicine for high blood pressure .... YES NO
   d. Cortisone (steroids) .... YES NO
   e. Tranquilizers .... YES NO
   f. Aspirin .... YES NO
   g. Insulin, Tolbutamide (Orinase) .... YES NO
   h. Digitalis or drugs for heart trouble .... YES NO
   i. Nitroglycerin .... YES NO
   j. Other ____________
12. Are you allergic or have you reacted adversely to:
   a. Local anesthetics .... YES NO
   b. Penicillin or other antibiotics .... YES NO
   c. Sulfa drugs .... YES NO
   d. Barbiturates, sedatives or sleeping pills .... YES NO
   e. Aspirin .... YES NO
   f. Other .... YES NO

ARE YOU WEARING A PACEMAKER? .... YES NO

Are you HIV positive? .... YES NO
Do you have AIDS? .... YES NO

13. Have you had any serious trouble associated with any previous dental treatment? .... YES NO
   a. Are you having dental pain? .... YES NO
   b. Does food pack between your teeth? .... YES NO
   c. Do your gums bleed when you brush your teeth? .... YES NO
   d. Do you grind or clench your teeth? .... YES NO
   e. Do you have any pain in or near your ears? .... YES NO
   f. Have you ever had periodontal (pyorrhea) treatment? .... YES NO
   g. Have you ever been instructed in proper home care of your teeth? .... YES NO
   h. Do you have any sores or lumps in your mouth? .... YES NO
   i. Are your teeth sensitive to:
      1) Hot or cold .... YES NO
      2) Sweet of sour .... YES NO
   j. How often do you brush your teeth? ____________
      1) When? ____________
   k. How long do you use your tooth brush before replacing it? ____________
   l. Do you feel that you have had bad breath or an unpleasant taste in your mouth at times? .... YES NO
   m. Do you smoke? .... YES NO
      If so, how much? ____________
14. Do you have any disease, condition or problem not listed above that you think I should know about?
   ____________ YES NO

WOMEN

15. Are you pregnant? .... YES NO
16. Do you have any problems associated with your menstrual period? .... YES NO
17. Are you taking birth control pills? .... YES NO

I UNDERSTAND THAT IT IS MY OBLIGATION TO INFORM THIS OFFICE OF ANY CHANGES IN THIS MEDICAL HISTORY.

____________ Signature of Patient or Guardian

____________ Date