



Name and city of current medical physician: \_\_\_\_\_

Date of last physical examination at your medical doctor's office, approximately: \_\_\_\_\_

**Please circle YES or NO**

- 1. Yes No Have you been under the care of a physician in the past 2 years? \_\_\_\_\_
- 2. Yes No Have you had a recent illness or surgery? \_\_\_\_\_
- 3. Yes No Have you ever been hospitalized? \_\_\_\_\_
- 4. Yes No Are you pregnant? \_\_\_\_\_

**HAVE YOU EVER HAD OR DO YOU HAVE:**

- 5. Yes No Heart trouble or heart surgery? \_\_\_\_\_
- 6. Yes No Pains in the chest or shortness of breath? \_\_\_\_\_
- 7. Yes No High blood pressure or stroke? \_\_\_\_\_
- 8. Yes No Rheumatic fever or heart murmur? \_\_\_\_\_
- 9. Yes No Anemia (low blood) or other blood diseases? \_\_\_\_\_
- 10. Yes No Thyroid trouble? \_\_\_\_\_
- 11. Yes No Jaundice, hepatitis or liver problems? \_\_\_\_\_
- 12. Yes No Diabetes or family history of diabetes? \_\_\_\_\_
- 13. Yes No Any breathing problems (hay fever, asthma, tuberculosis, sinusitis, emphysema)? \_\_\_\_\_
- 14. Yes No Stomach or intestinal problems (ulcers, etc.)? \_\_\_\_\_
- 15. Yes No Kidney or bladder problems? \_\_\_\_\_
- 16. Yes No Cancer or tumors? \_\_\_\_\_
- 17. Yes No Convulsions, seizures, or fainting? \_\_\_\_\_
- 18. Yes No Abnormal or prolonged bleeding? \_\_\_\_\_
- 19. Yes No Syphilis, gonorrhea, social herpes, or AIDS? \_\_\_\_\_
- 20. Yes No Scalp or skin disease? \_\_\_\_\_
- 21. Yes No Arthritis, bone disease, joint problems or replacement? \_\_\_\_\_
- 22. Yes No Eye problems (glaucoma, retinal repair, etc.)? \_\_\_\_\_
- 23. Yes No Use of alcohol, drugs or tobacco? \_\_\_\_\_
- 24. Yes No Sudden weight loss or weight gain? \_\_\_\_\_
- 25. Yes No Lumps in your neck, armpits, or groin? \_\_\_\_\_
- 26. Yes No Recent appearance of discolored areas in your mouth or other parts of your body? \_\_\_\_\_
- 27. Yes No Any other medical condition that we should be aware of? \_\_\_\_\_

**ARE YOU TAKING NOW OR HAVE YOU TAKEN WITHIN THE LAST 2 YEARS:**

- 28. Yes No Cortisone/Steroids, anti-rejection drugs? \_\_\_\_\_
- 29. Yes No Blood thinners (Coumadin, Warfarin, Heparin)? \_\_\_\_\_
- 30. Yes No Tranquilizers, sedatives, or pain drugs (aspirin)? \_\_\_\_\_
- 31. Yes No Nitroglycerin or other heart medications? \_\_\_\_\_
- 32. Yes No Any other medicine or drugs (including birth control pills)? \_\_\_\_\_
- 33. Yes No Are you currently taking any herbal or natural homeopathic remedies? \_\_\_\_\_

If so, are you under the supervision of an alternative therapist? \_\_\_\_\_

**HAVE YOU EVER HAD A REACTION OR ALLERGY (LIKE ITCHING, RASH, OR SWELLING) TO:**

- 34. Yes No Local anesthetics (Novocaine, Xylocaine, etc.)? \_\_\_\_\_
- 35. Yes No Penicillin, sulfa drugs or other antibiotics? \_\_\_\_\_
- 36. Yes No Other drugs or medicines? \_\_\_\_\_

PLEASE COMPLETE BACK OF THIS PAGE

**HEALTH QUESTIONNAIRE**

Last dental visit approximately: \_\_\_\_\_

What is your immediate dental concern? \_\_\_\_\_

**Please circle YES or NO**

- 1.    Yes    No    Are you presently in any dental pain? \_\_\_\_\_
- 2.    Yes    No    Have you ever had an unfavorable experience in the dental office? \_\_\_\_\_
- 3.    Yes    No    Have you ever had orthodontic treatment (braces)? \_\_\_\_\_
- 4.    Yes    No    Have you ever had periodontal (gum) treatment? \_\_\_\_\_
- 5.    Yes    No    Do you have any growths or swellings in your mouth? \_\_\_\_\_  
How long have they existed? \_\_\_\_\_
- 6.    Yes    No    Is any part of your mouth sensitive to temperature extremes, toothbrushing, chewing  
pressure or sweets? \_\_\_\_\_
- 7.    Yes    No    Does food catch between your teeth more than expected? \_\_\_\_\_
- 8.    Yes    No    Do you have any pain or soreness in your head and neck area? \_\_\_\_\_
- 9.    Yes    No    Are you aware of clenching or grinding your teeth while you're awake or sleeping? \_\_\_\_\_
- 10.   Yes    No    Does your jaw click or pop while eating or yawning? \_\_\_\_\_
- 11.   Yes    No    Do you have frequent headaches? \_\_\_\_\_
- 12.   Yes    No    Are you dissatisfied with your teeth and their appearance? \_\_\_\_\_
- 13.   Yes    No    Do you feel you will eventually wear dentures? \_\_\_\_\_
- 14.   Yes    No    Do you want to retain your teeth? \_\_\_\_\_
- 15.   Yes    No    Do you frequently consume sweets? \_\_\_\_\_
- 16.   Yes    No    Do you snore while sleeping? (not a joke) \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health status, or if any of my medications change, I will inform the dentist at the next appointment without fail.

Patient/Legal Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Updated Medical History, Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Updated Medical History, Patient signature \_\_\_\_\_ Date \_\_\_\_\_

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**DOCTOR'S NOTES**