GENERAL HEALTH INFORMATION

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DATE:____________________

PATIENT NAME:____________________ (LAST) ____________________ (FIRST) BIRTHDATE:____________ AGE:______

DENTAL HISTORY

1. Why are you here today? ____________________
2. Are you having any pain in your teeth or gums? **YES** ☐ **NO** ☐ If yes, please specify: ____________
3. When did you last visit a dentist? ____________
4. What treatment was performed? ____________
5. Was the treatment completed? ____________
6. When was your last cleaning? ____________
7. When were dental X-Rays taken? ____________
8. Last dentist's name? ____________
9. Reason for leaving? ____________
10. Have you ever had prolonged bleeding after an extraction? **YES** ☐ **NO** ☐ If yes, please specify: ____________
11. Have you had any problems with past dental treatment? **YES** ☐ **NO** ☐ If yes, please specify: ____________
12. Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain or locking open, or have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction, sometimes called TMJ)? **YES** ☐ **NO** ☐ If yes, please specify: ____________
13. Have you ever been treated for bruxism (i.e. tooth grinding) or clenching? **YES** ☐ **NO** ☐ If yes, please specify: ____________
14. Do you participate in any contact sports? **YES** ☐ **NO** ☐ Specify: ____________
15. Do you wear a sports mouth guard or a niteguard? **YES** ☐ **NO** ☐ If yes, please specify: ____________
16. Do your gums bleed easily? **YES** ☐ **NO** ☐
17. Do you feel you have bad breath? **YES** ☐ **NO** ☐
18. Are your teeth sensitive to hot or cold? **YES** ☐ **NO** ☐
19. Would you like your teeth whiter? **YES** ☐ **NO** ☐
20. Are you happy with your smile? **YES** ☐ **NO** ☐ If no, please specify what you would change? ____________
21. Are there any other dental conditions we should be aware of? **YES** ☐ **NO** ☐ If yes, please specify: ____________

MEDICAL HISTORY

1. Physician's Name: ____________
2. Are you under a physician's care at this time? **YES** ☐ **NO** ☐ Physician's Ph # (____)________ City: ________ Condition: ____________
3. Are you allergic to: ☐ penicillin ☐ codeine ☐ local anesthetics ☐ tranquilizers ☐ other drugs or medicine? Specify:
4. Are you allergic to latex or any metals? **YES** ☐ **NO** ☐ If yes, please specify: ____________
5. Are you taking any medications at this time, including birth control and non-prescriptions (over the counter medication)? **YES** ☐ **NO** ☐ If yes, please specify: ____________
6. (Woman) Are you pregnant at this time? **YES** ☐ **NO** ☐________ Nursing? **YES** ☐ **NO** ☐ ________

7. Do you have, or have you had any of the following?

Please check YES or NO			Doctor's Comments
ARTIFICIAL HEART VALVE	YES ☐	NO ☐	
AIDS/HIV+	YES ☐	NO ☐	
ALCOHOL ABUSE	YES ☐	NO ☐	
ANEMIA	YES ☐	NO ☐	
ANGINA	YES ☐	NO ☐	
ARTHRITIS	YES ☐	NO ☐	
ASTHMA	YES ☐	NO ☐	
BISPHOSPHONATES (FOSOMAX / BONIVA, ETC.)	YES ☐	NO ☐	
BLEEDING PROBLEMS	YES ☐	NO ☐	
CANCER	YES ☐	NO ☐	
CHEMO/RAD THERAPY	YES ☐	NO ☐	
COSMETIC SURGERY	YES ☐	NO ☐	
DIABETES	YES ☐	NO ☐	
DIZZY SPELLS	YES ☐	NO ☐	
DRUG ADDICTION	YES ☐	NO ☐	
EMPHYSEMA	YES ☐	NO ☐	
EPILEPSY	YES ☐	NO ☐	
FAINTING	YES ☐	NO ☐	
GLAUCOMA	YES ☐	NO ☐	

Please check YES or NO			Doctor's Comments
HEART ATTACK	YES ☐	NO ☐	
HEART MURMUR	YES ☐	NO ☐	
HEART PROBLEMS/SURGERY	YES ☐	NO ☐	
HEPATITIS	YES ☐	NO ☐	
HIGH BLOOD PRESSURE	YES ☐	NO ☐	
JAUNDICE	YES ☐	NO ☐	
JOINT PROSTHESIS	YES ☐	NO ☐	
KIDNEY DISEASE	YES ☐	NO ☐	
LIVER PROBLEMS	YES ☐	NO ☐	
LOW BLOOD PRESSURE	YES ☐	NO ☐	
LUNG DISEASE	YES ☐	NO ☐	
PACEMAKER	YES ☐	NO ☐	
PSYCHIATRIC CARE	YES ☐	NO ☐	
RHEUMATIC FEVER	YES ☐	NO ☐	
SHORTNESS OF BREATH	YES ☐	NO ☐	
SINUS TROUBLE	YES ☐	NO ☐	
SMOKING TOBACCO	YES ☐	NO ☐	
STROKE	YES ☐	NO ☐	
THYROID PROBLEMS	YES ☐	NO ☐	
TMD OR TMJ	YES ☐	NO ☐	
TUBERCULOSIS	YES ☐	NO ☐	
VENEREAL DISEASE	YES ☐	NO ☐	

8. Are there any other health problems of which we should be advised? Please specify: ____________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of X-Rays and an oral examination.

Patient's Signature:____________________ **Date**________ Doctor's Signature: ____________
(or Parent/Guardian, if patient is a minor)

RECALL REVIEW: My signature below indicates I have reviewed my health history, and initialed and dated any changes since the last review.

1. Patient's signature:____________ Date______ Doctor's Signature: ____________
2. Patient's signature:____________ Date______ Doctor's Signature: ____________
3. Patient's signature:____________ Date______ Doctor's Signature: ____________
4. Patient's signature:____________ Date______ Doctor's Signature: ____________
5. Patient's signature:____________ Date______ Doctor's Signature: ____________