Last Name First Initial

Date of Birth Today's Date

E-mail Address

MEDICAL HISTORY

Please **check** the correct response.
All responses will be considered confidential information.

Do you have or have you had any of the following:

Cardiovascular and Blood Disorders

1. Rheumatic fever? Yes ○ No ○ Don't know ○
2. Hypertension (high blood pressure)? Yes ○ No ○ Don't know ○
3. Heart attack, irregular heart rate, damaged heart valves or angina? Yes ○ No ○ Don't know ○
4. Stroke? Yes ○ No ○ Don't know ○
5. Heart murmur? Yes ○ No ○ Don't know ○
6. Chest pain or shortness of breath on exertion? Yes ○ No ○ Don't know ○
7. Swollen ankles? Yes ○ No ○ Don't know ○
8. Blood disorders such as anemia or hemophilia? Yes ○ No ○ Don't know ○
9. Frequent nosebleeds, increased bruising or bleeding? Yes ○ No ○ Don't know ○

Allergies and Immune System

10. Asthma, tuberculosis or hay fever? Yes ○ No ○ Don't know ○
11. Have you ever had a reaction to any drugs? Yes ○ No ○ Don't know ○
    If Yes, which drugs? _____
12. Do you have any allergies? Yes ○ No ○ Don't know ○
13. Are you immunosuppressed (subject to frequent infection)? Yes ○ No ○ Don't know ○
14. Have you been told you have AIDS, ARC or a positive HIV test? Yes ○ No ○ Don't know ○

Gastrointestinal

15. Ulcers, stomach or intestinal problems? Yes ○ No ○ Don't know ○
16. Hepatitis (jaundice) or liver disease? Yes ○ No ○ Don't know ○

Endocrine

17. Diabetes (high blood sugar)? Yes ○ No ○ Don't know ○
18. Frequent urination (six times/day), kidney disease or dialysis? Yes ○ No ○ Don't know ○
19. Increase in thirst? Yes ○ No ○ Don't know ○

Central Nervous System

20. History of convulsions, seizure or epilepsy? Yes ○ No ○ Don't know ○
21. Tendency to faint? Yes ○ No ○ Don't know ○

Habits

22. Do you now use or have you ever used tobacco products? Yes ○ No ○ Don't know ○
23. How many alcoholic drinks do you consume in a...
    day? _____ week? _____ month? _____

Medications

24. Are you taking any medications now? Yes ○ No ○ Don't know ○
    If Yes, please list all prescription and non-prescription drugs.

    _____

    _____

Eyes, Ears, Nose, Throat

25. Do you get frequent or severe headaches? Yes ○ No ○ Don't know ○
26. Have you ever had eye, ear, nose or sinus problems? Yes ○ No ○ Don't know ○
27. Do you have difficulty swallowing? Yes ○ No ○ Don't know ○

General

28. Are you in good health? Yes ○ No ○ Don't know ○
29. Arthritis (painful, swollen joints)? Yes ○ No ○ Don't know ○
30. Have you ever had an artificial joint placed? Yes ○ No ○ Don't know ○
31. Cancer, chemotherapy or radiation therapy? Yes ○ No ○ Don't know ○
32. A blood transfusion? Yes ○ No ○ Don't know ○
33. Are you being treated by a physician now? Yes ○ No ○ Don't know ○
    If Yes, for what condition? _____
34. Been hospitalized, had major surgery or been seriously hurt? Yes ○ No ○ Don't know ○
35. Do you have any further questions, concerns
    or additional information? Yes ○ No ○ Don't know ○
    If Yes, please specify. _____

36. Are you pregnant? Yes ○ No ○ Don't know ○

37. Physician's name and address: _____

_____

Dental History

1. What is the reason for your dental visit? _____

_____

2. Have you ever had any complications following dental treatment? Yes ○ No ○ Don't know ○
3. Are you concerned about receiving dental anesthetic? Yes ○ No ○ Don't know ○
4. Have you ever had a bad reaction to a local dental anesthetic? Yes ○ No ○ Don't know ○
5. Have you ever had nitrous oxide (laughing gas)? Yes ○ No ○ Don't know ○
6. Have you ever had a severe injury to your face, teeth or jaw? Yes ○ No ○ Don't know ○
7. Have you ever had surgery in your mouth or on your lips? Yes ○ No ○ Don't know ○
8. Have you ever had radiation treatment of your neck or head? Yes ○ No ○ Don't know ○
9. How many times a year do you get your teeth cleaned? _____
10. How many times a day do you brush your teeth? _____ Floss? _____
11. Are your teeth sensitive to hot, cold or pressure? Yes ○ No ○ Don't know ○
12. Do you have bleeding gums? Yes ○ No ○ Don't know ○
13. Do you ever have frequent or recurrent sores in your mouth? Yes ○ No ○ Don't know ○
14. Have you ever had periodontal treatment for your gums? Yes ○ No ○ Don't know ○
15. Have you ever had orthodontic treatment to straighten your teeth? Yes ○ No ○ Don't know ○
16. Have you had a recent toothache? Yes ○ No ○ Don't know ○
17. Have you ever had extraction of any teeth? Yes ○ No ○ Don't know ○
    If Yes, for what reason? _____
18. Have you ever had root canals (endodontics) on any teeth? Yes ○ No ○ Don't know ○
19. Do you have trouble chewing? Yes ○ No ○ Don't know ○
20. Do you clench or grind your teeth? Yes ○ No ○ Don't know ○
21. Do you have any difficulty opening your mouth as wide as you would like? Yes ○ No ○ Don't know ○
22. Are you aware of any oral habits such as mouth-breathing, nail-biting, etc.? Yes ○ No ○ Don't know ○
23. Is your drinking water from city sources (is it fluoridated)? Yes ○ No ○ Don't know ○
24. Do you consider yourself to be a good dental patient? Yes ○ No ○ Don't know ○
25. Does your jaw click, pop or hurt when you chew? Yes ○ No ○ Don't know ○
26. Please circle the amount of sugar in your diet. Large ○ Medium ○ Small ○
27. Have you had any missing teeth replaced by a removable denture or fixed bridge? Yes ○ No ○ Don't know ○
28. Are you satisfied with the replacement? Yes ○ No ○ N/A ○
29. Are any of your teeth loose? Yes ○ No ○ Don't know ○

30. Are you satisfied with the appearance of your teeth? Yes ○ No ○ Don't know ○

31. Do you have any further questions, concerns or additional information? Yes ○ No ○ Don't know ○

If Yes, please specify. _____

_____

32. What is the name of your previous dentist? _____

_____

I certify that to the best of my knowledge the above information is complete and accurate.

Patient's signature _____ **Date** _____

Examiner's comments _____

_____

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Reviewed by: _____

Review and update of questionnaire Date _____ Sig _____

Review and update of questionnaire Date _____ Sig _____

Review and update of questionnaire Date _____ Sig _____

Review and update of questionnaire Date _____ Sig _____

Review and update of questionnaire Date _____ Sig _____

Print Form