TELL US ABOUT YOUR HEALTH!

When was your last physical exam? _____
Physician's name and phone number_____
List any medicines you take, and the dosages_____
List any vitamins you take, and the amounts_____
Date of birth _____

YES NO Are you allergic to any medicines ? If so, what?_____
YES NO Do you have any other allergies? If so, to what?_____
YES NO Are you sensitive to any metals, latex, or other substances? If so, to what?_____
YES NO Are you pregnant or suspect you may be?
YES NO Do you use birth control medications?_____
YES NO Have you ever been treated for or been told you might have heart disease?
YES NO Do you have a pacemaker or an artificial heart valve?
YES NO Have you ever had rheumatic fever?
YES NO Do you have any heart murmurs?
YES NO Do you have high or low blood pressure?_____
YES NO Have you ever had a serious illness or major surgery? If so, list types and approximate dates:_____
_____
YES NO Have you ever been treated for any tumor or cancer?_____
YES NO Do you have inflammatory diseases, such as arthritis or rheumatism?_____
YES NO Do you have any artificial joints?_____
YES NO Do you have any blood disorders, such as anemia, leukemia, etc.?_____
YES NO Do you bleed excessively compared to most people?_____
YES NO Do you have any stomach problems?_____
YES NO Do you have any kidney problems?_____
YES NO Do you have any liver problems?_____
YES NO Are you diabetic? If so, how is it controlled?_____
YES NO Do you have asthma? If so, how frequent are attacks?_____
YES NO Do you have epilepsy or seizure disorders? If so, how frequent are attacks?_____
YES NO Do you have or have you had any venereal disease?_____
YES NO Are you HIV positive? (Infected with the AIDS virus?)
YES NO Have you had or do you test positive for hepatitis?
YES NO Do you have or have you ever had Tuberculosis (T.B.)?
YES NO Do you smoke, chew, use snuff or any other form of tobacco? How much?_____
YES NO Do you consume alcoholic beverages? How frequently?_____
YES NO Do you have any disease, condition, or problem not covered in this form?_____
YES NO Is there anything else we should know about your health? What?_____

What is your biggest concern bringing you to our office?_____
Are you happy with the appearance of your teeth?_____
Do you feel you can chew adequately?_____
Have you ever had a toothache?_____
When was your last dental visit, and what was it for?_____
Your previous dentist's name, and why you left. (confidential)_____
Are you frightened of dental visits? Please explain._____
How do you care for your teeth each day?_____
Do you grind or clench your teeth?_____
Are any teeth sensitive?_____
Does your jaw click, pop, or lock, or do you have jaw soreness?_____
Describe your diet_____
List any mouth habits (nail biting, gum chewing, finger sucking, etc.)_____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE RESPONSES ARE COMPLETE AND ACCURATE

Patient signature_____Date_____

Dentist signature_____Date_____