

*"Creating healthy, beautiful smiles....for a lifetime."*

**YOUR NAME:** \_\_\_\_\_ Today's Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ When was your last visit to your physician? \_\_\_\_\_

## MEDICAL History

When was your last complete physical? \_\_\_\_\_

Please tell us if you have had any of the following by checking the appropriate box:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Bacterial Endocarditis   | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Any Artificial Replacement | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Blood Disease            | Artificial Knee, Hip, Joint,                        | <input type="checkbox"/> Kidney Problems       |
| <input type="checkbox"/> Irregular Heart Beat     | <input type="checkbox"/> Sickle Cell Anemia       | Pins, Plate   | <input type="checkbox"/> Dialysis              |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Anemia / Blood Problems  | <input type="checkbox"/> Rheumatism / Arthritis     | <input type="checkbox"/> Liver Problems        |
| <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Excessive Bleeding       | <input type="checkbox"/> Neurological Problems      | <input type="checkbox"/> Hepatitis             |
| <input type="checkbox"/> Rheumatic Heart Fever    | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Epilepsy / Seizures        | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Rheumatic Heart Disease  | <input type="checkbox"/> Respiratory Disease      | <input type="checkbox"/> Psychiatric Problems       | <input type="checkbox"/> Thyroid Problems      |
| <input type="checkbox"/> Artificial Heart Valves  | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Emotional Problems         | <input type="checkbox"/> Ulcer / Colitis       |
| <input type="checkbox"/> Congenital Heart Lesion  | <input type="checkbox"/> Hay Fever                | <input type="checkbox"/> Alcoholism                 | <input type="checkbox"/> Venereal Disease      |
| <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Chemical Dependency        | <input type="checkbox"/> Herpes                |
| <input type="checkbox"/> Heart Attack _____ year  | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Drug Addiction             | <input type="checkbox"/> Fever Blisters        |
| <input type="checkbox"/> Angina/ Chest Pain       | <input type="checkbox"/> Eye Disorders / Glaucoma | <input type="checkbox"/> Malignancies               | <input type="checkbox"/> Pregnant _____ months |
| <input type="checkbox"/> Heart Pacemaker          | <input type="checkbox"/> AIDS                     | <input type="checkbox"/> Cancers, Tumors, Growths   | <input type="checkbox"/> Oral Contraceptives   |
| <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Immunosuppressive        | <input type="checkbox"/> Radiation Treatments       |  |
| <input type="checkbox"/> Congestive Heart Failure | Disorders / ARC                                   |   |  |

Please list any ALLERGIES to Drugs, Medications or Anesthetics: \_\_\_\_\_  
\_\_\_\_\_

Please list any other MEDICAL CONDITIONS not mentioned above: \_\_\_\_\_  
\_\_\_\_\_

Please list all DRUGS/MEDICATIONS that you currently take:  
(Include the dosage and frequency that you are on) \_\_\_\_\_  
\_\_\_\_\_

## DENTAL History

Please describe your chief oral complaint: \_\_\_\_\_  
\_\_\_\_\_

- |   |                          |                          |  |
|---|--------------------------|--------------------------|--|
| Are your teeth sensitive to :                                   | Yes                      | No                       |  |
| Heat?   | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a complete dental examination,  |
| Cold?   | <input type="checkbox"/> | <input type="checkbox"/> | including full mouth x-rays, in the past 3 years? <span style="float: right;">Yes No</span>  |
| Sweets?   | <input type="checkbox"/> | <input type="checkbox"/> | Have you had your teeth cleaned regularly? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>            |
| Chewing?  | <input type="checkbox"/> | <input type="checkbox"/> | When was your last cleaning? _____   |
| Do you have any food traps?                                     | <input type="checkbox"/> | <input type="checkbox"/> | Do you have all or most of your natural teeth? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>        |
| Do your gums ever feel tender or swollen?                       | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to keep your natural teeth? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>            |
| Do your gums bleed when brushing?                               | <input type="checkbox"/> | <input type="checkbox"/> | If you've had teeth removed, have they been replaced? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span> |
| Do you have any teeth that feel loose?                          | <input type="checkbox"/> | <input type="checkbox"/> | Do you like the appearance of your smile? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>             |
| Have you ever been treated for periodontal disease or pyorrhea? | <input type="checkbox"/> | <input type="checkbox"/> | If you could improve your teeth or smile, what would you do?<br>_____  |
| Do you use dental floss?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Have you had any previous injuries to your face or jaws?        | <input type="checkbox"/> | <input type="checkbox"/> | Do you consider yourself a nervous dental patient? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>    |
| Do you lose or break fillings?                                  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an unpleasant dental experience? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>    |
| Do you clench or grind your teeth?                              | <input type="checkbox"/> | <input type="checkbox"/> | When was your last dental appointment? _____   |
| Do you seem to strike some teeth before others when closing?    | <input type="checkbox"/> | <input type="checkbox"/> | What was done at that visit? _____   |
| Have you ever had your bite adjusted?                           | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Do your jaws ever feel tired or ache?                           | <input type="checkbox"/> | <input type="checkbox"/> | Where was it done? _____   |
| Can you chew comfortably on both sides of your mouth?           | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever experienced problems with novocaine? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>    |