MEDICAL HISTORY

	YES	NO		YES	NO
Are you in good health at the present time?	❑	❑	Do you bruise easily?	❑	❑
Are you under current medical treatment?	❑	❑	Are you on a special diet?	❑	❑
Are you taking any medication? List Medication(s)	❑	❑	If female, are you pregnant?	❑	❑

Please check any of the following conditions you have, or have had:

- ❑ Heart Valve Defect (murmur)
- ❑ High or Low Blood Pressure
- ❑ Emotional Problems
- ❑ Artificial Joint Replacement
- ❑ Injury to teeth or jaw
- ❑ Artificial Heart Valves
- ❑ Dizziness or Fainting
- ❑ Radiation Treatment
- ❑ Epilepsy
- ❑ Stroke
- ❑ Bleeding Disorder
- ❑ Heart Disease
- ❑ Pacemaker
- ❑ Endocarditis
- ❑ Convulsions
- ❑ T.B.
- ❑ Asthma
- ❑ Osteopenia or Osteoporosis
- ❑ Rheumatic Fever
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Ulcer
- ❑ Immune System Disorder
- ❑ Thyroid Disorder
- ❑ Cancer(s)

Date of last Physical Exam _____

Name of Physician(s) _____

Address _____

Please check allergies to any of these:

- ❑ Antibiotics
- ❑ Aspirin
- ❑ Codeine
- ❑ Novocaine
- ❑ Demerol
- ❑ Penicillin
- ❑ Antihistamines
- ❑ Barbiturates
- ❑ Sulfa
- ❑ Latex
- ❑ Ibuprofen

Please list past serious illness, injuries, and operations:

_____

_____

_____

Have you ever taken the diet drug combination "Fen-Phen"? Yes _____ No _____

Are you or have you ever taken medication for Osteoporosis or Osteopenia? Yes_____ No_____

DENTAL HISTORY

Date of last dental cleaning and examination: _____

By Dr.: _____ City: _____

	YES	NO	UPDATE
Was all your treatment completed at that time?	❑	❑	
Chief dental complaint today? _____	❑	❑	
Are you in dental pain now? Lately?	❑	❑	
Are there any sores or growths in your mouth?	❑	❑	
Do your gums bleed easily?	❑	❑	
Have you ever received treatment for gum disease?	❑	❑	
Do you have any sensitive teeth or chew only on one side of your mouth?	❑	❑	
Have you ever had your teeth straightened?	❑	❑	
Have you ever had prolonged bleeding after a cut or an extraction?	❑	❑	
Are you unhappy with the appearance of your teeth?	❑	❑	
Are you aware of clenching or grinding your teeth?	❑	❑	
Do you smoke?	❑	❑	
Do your jaws click when you open your mouth widely?	❑	❑	
Are you prone to headaches?	❑	❑	
Have you ever had an unfavorable dental experience?	❑	❑	
Do you object to the use of local anesthetics: "Novocaine"?	❑	❑	
Do you wish to use Nitrous Oxide during treatment?	❑	❑	

_____

Signature Date