GENERAL HEALTH INFORMATION

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

DENTAL HISTORY

1. Are there other conditions of which we should be aware? YES ____ NO ____ If yes, please specify: _____
2. Why are you here today? Check-Up _____ Cleaning _____ Other _____
   Toothache _____ Chief Complaint _____
3. When did you last visit a dentist? _____ 4. What treatment was performed? _____
5. Was the treatment completed? _____ 6. Did you have a cleaning? _____
7. When were dental x-rays taken? _____
8. Have you ever had prolonged bleeding after an extraction? YES ___ NO ___ If yes, please specify: _____
9. Have you had any problems with past dental treatment? YES ____ NO ____ If yes, please specify: _____
10. Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain or locking open?
    YES ____ NO ____ If yes, please specify: _____
11. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction sometimes called TMJ)?
    YES ____ NO ____ If yes, please specify: _____
12. Do your gums bleed easily? YES _____ NO _____ 13. Do you feel you have had breath? YES _____ NO _____
14. Are your teeth sensitive to hot or cold? YES _____ NO _____ 15. Would you like your teeth whiter? YES _____ NO _____
16. Are there any cosmetic changes you would like to have done on your teeth? YES _____ If yes, please specify: _____

MEDCIAL HISTORY

1. Are you under a Doctor's care at this time? YES ____ NO ____ If yes, please specify: Dr. Name: _____
   Dr. Ph. #: ( ) _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES ___ NO ___ If yes, please specifiy: _____
4. (Woman) Are you pregnant at this time? YES ____ NO ____ If yes, please specify how many moths: _____
5. Are there any other health problems of which we should advised? Please specify: _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"			Doctor Comments	Please check "YES" or "NO"			Doctor Comments
ARTIFICIAL Heart Valve	YES ❑	NO ❑	_____	HEPATITIS	YES ❑	NO ❑	_____
AIDS/HIV+	YES ❑	NO ❑	_____	HIGH BL. PRESSURE	YES ❑	NO ❑	_____
ANEMIA	YES ❑	NO ❑	_____	JAUNDICE	YES ❑	NO ❑	_____
ANGINA	YES ❑	NO ❑	_____	JOINT PROSTHESIS	YES ❑	NO ❑	_____
ARTHRITIS	YES ❑	NO ❑	_____	KIDNEY DISEASE	YES ❑	NO ❑	_____
ASTHMA	YES ❑	NO ❑	_____	LATEX ALLERGY	YES ❑	NO ❑	_____
BLEEDING PROBLEMS	YES ❑	NO ❑	_____	LIVER PROBLEMS	YES ❑	NO ❑	_____
CANCER	YES ❑	NO ❑	_____	LOW BL. PRESSURE	YES ❑	NO ❑	_____
CHEMO/RAD THERAPY	YES ❑	NO ❑	_____	LUNG DISEASE	YES ❑	NO ❑	_____
COSMETIC SURGERY	YES ❑	NO ❑	_____	PACEMAKER	YES ❑	NO ❑	_____
DIABETES	YES ❑	NO ❑	_____	PHEN-FEN	YES ❑	NO ❑	_____
DIZZY SPELLS	YES ❑	NO ❑	_____	PSYCHIATRIC CARE	YES ❑	NO ❑	_____
DRUG ADDICTION	YES ❑	NO ❑	_____	RHEUMATIC FEVER	YES ❑	NO ❑	_____
EMPHYSEMA	YES ❑	NO ❑	_____	SINUS TROUBLE	YES ❑	NO ❑	_____
EPILEPSY	YES ❑	NO ❑	_____	SMOKING TOBACCO	YES ❑	NO ❑	_____
FAINTING	YES ❑	NO ❑	_____	STROKE	YES ❑	NO ❑	_____
GLAUCOMA	YES ❑	NO ❑	_____	THYROID PROBLEMS	YES ❑	NO ❑	_____
HEART ATTACK	YES ❑	NO ❑	_____	TMD OR TMJ	YES ❑	NO ❑	_____
HEART SURGERY	YES ❑	NO ❑	_____	TUBERCULOSIS	YES ❑	NO ❑	_____
HEART MURMUR	YES ❑	NO ❑	_____	VENEREAL DISEASE	YES ❑	NO ❑	_____
HEART PROBLEMS	YES ❑	NO ❑	_____				

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 oral examination.

Patient's signature _____ Date _____
For Parent if patient is a minor

Doctor Signature _____

RECALL REVIEW:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____