

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Soc.Sec.No. \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

Approximate date of last physical examination \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1.) Are you under any medical treatment now?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.) Have you had any major operations? If so, what?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.) Have you ever had a serious accident involving head injuries?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.) Have you had any adverse response to any drugs including penicillin?              | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.) Has a physician ever informed you that you had: A heart ailment?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. High Blood Pressure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Respiratory Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Diabetes?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Rheumatic Fever?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Rheumatism or Arthritis?   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Tumors or Growths?   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Any Blood Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Any Liver Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Any Kidney Disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any Stomach or Intestinal Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Any Venereal Disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. AIDS?  | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Yellow Jaundice or Hepatitis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.) Do you have night sweats accompanied by weight loss or cough?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.) Are you on a diet at this time?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.) Are you now taking drugs or medications?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.) Are you allergic to any known materials resulting in hives, asthma, eczema, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10.) Are you in general good health at this time?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.) Have any wounds healed slowly or presented other complications?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12.) Are you pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13.) Do you have a history of fainting?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.) Have you ever had any X-Ray TREATMENTS (other than diagnostic)?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15.)  |                          |                          |

**PATIENT DENTAL HISTORY**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 16.) Do you have pain in or near your ears?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 17.) Do you have any unhealed injuries or inflamed areas in or around you mouth?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18.) Have you experienced any growth or sore spots in your mouth?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 19.) Does any part of your mouth hurt when clenched?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 20.) Have you ever had Novocain anesthetic?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Any reactions or allergic symptoms to Novocain?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Any difficult extractions in the past?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Prolonged bleeding following extractions in the past?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Trench Mouth?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 37.) Do your gums bleed?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 38.) Have you ever had instructions on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39.) Have you ever had instructions on the care of your gums?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 40.) Do you chew on only one side of your mouth? If so, why?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 41.) Do you at the present time have any dental complaints?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 42.) Do you habitually clench your teeth during the night or day?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 43.) When was your last full mouth X-Ray taken? _____ Where? _____                |                          |                          |
| 44.) Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)   | <input type="checkbox"/> | <input type="checkbox"/> |
| If so locate _____  |                          |                          |

Signature \_\_\_\_\_