Patient Name _____ Birthdate _____ Date _____ Marital Status _____

Residence Address _____ Telephone _____
Street City State Zip

Business Address _____ Telephone _____

Occupation Self _____ Soc. Sec. No. _____

Occupation Spouse _____ Soc. Sec. No. _____

Responsible for Acct. _____ Dental Insurance Prog. _____

Dentist _____ Address _____ Telephone _____ Yrs. ____

Physician _____ Address _____ Telephone _____

Referred by _____ Reason for Referral _____

_____

MEDICAL HISTORY

Date of Last Physical Exam: _____

Are you presently under a physician's care?

If yes, for what condition: _____

Have you ever been hospitalized?

If yes, for what condition: _____

_____

Do you have or have you had any of the following problems?

	YES	NO
1. Hepatitis, jaundice or liver disease?		
2. Rheumatic fever		
3. Heart murmur		
4. Heart trouble or stroke		
Do any blood relatives have heart trouble?		
5. High or low blood pressure		
6. Chest pains, ankle swelling or shortness of breath		
7. Drug allergies or reactions		
If yes, what: _____		
8. Asthma, hay fever, sinus problems or allergies		
If yes, what: _____		
9. Epilepsy or seizures		
10. Diabetes		
a) Any blood relatives?		
b) Do you urinate frequently?		
c) Are you often thirsty?		
11. Arthritis or rheumatism		
12. Stomach or duodenal ulcers		
13. Kidney disease or infection		
14. Venereal disease		
15. Medical radiation treatments		
16. Glaucoma		

	YES	NO
17. Prostate problems		
18. Abnormal bleeding problems or blood disorders		
a) Anemia		
b) Clotting problems		
c) Other blood problems		
19. Do you take any drugs or medicines?		
If yes, what: _____		
20. Have you taken any other medications within the past year?		
If yes, what: _____		
21. Are you a nervous person?		
If yes, do you take medication for this condition?		
22. Do you wear contact lenses?		
23. Have you had any other serious illnesses or conditions which we should know about?		
If yes, what: _____		
24. Do you smoke?		
If yes, how much: _____		
Women:		
25. Are you pregnant?		
26. Do you take birth control medication?		
27. Are you post-menopause?		
28. Do you have problems with your menstrual cycle?		

DENTAL HISTORY

1. Have you ever had "trench mouth?"		
2. Have you ever had treatments for periodontal disease?		
3. Do your gums bleed?		
4. Do your teeth feel loose?		
5. Do you grind or clench your teeth or jaws during the day or night?		
6. Do you have sore or sensitive teeth?		
7. Do you have pain elsewhere in your face or jaws?		

8. How long have you known about your gum condition? _____		
9. Have you ever had your teeth straightened? (Orthodontics) If yes, when: _____		
10. How often do you brush your teeth? _____		
11. Do you use dental floss, toothpicks, water irrigation or other devices?		
If yes, how often: _____		
12. How often do you have your teeth cleaned? _____		

Comments: _____

_____

_____

_____

_____

_____

_____