

Dental History and Information

Are your teeth sensitive to heat or cold, pressure, or sweets? Yes NO Specify : _____
 Do your gums bleed when you brush? Yes NO
 Do you clench or grind your teeth? Yes NO
 Are you having pain or discomfort at this time? Yes NO
 When was your last exam? _____
 When was your last Cleaning? _____

Medical History and Information

Are you under a physician's care now? Yes NO Reason _____
 Have you been hospitalized in the past two years? Yes NO Reason _____
 Are you taking any drugs or medications? Yes NO Reason _____
Do you have artificial joints/pins ? Yes NO Where? _____

If female please answer the following:

Y N <input type="radio"/> <input type="radio"/> Are you taking Birth Control Pills? <input type="radio"/> <input type="radio"/> Are you pregnant? # of weeks? <input type="text"/> <input type="radio"/> <input type="radio"/> Are you nursing?
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Please answer the following:

Y N <input type="radio"/> <input type="radio"/> Do you smoke or use tobacco?

Please CIRCLE Y (yes) or N (no) to all of the following:

<u>Conditions</u>	<u>Conditions</u>	<u>Conditions</u>
Y N Abnormal Bleeding	Y N Glaucoma	Y N Stroke
Y N Alcohol Abuse	Y N Hay Fever	Y N Thyroid Problems
Y N Allergies	Y N Heart Attack	Y N Tuberculosis
Y N Anemia	Y N Heart Surgery	Y N Ulcers
Y N Angina Pectoris	Y N Hemophilia	Y N Venereal Disease
Y N Arthritis	Y N Hepatitis A	Y N Yellow Jaundice
Y N Artificial Bones	Y N Hepatitis B	Y N Heart Murmur
Y N Artificial Heart Valve	Y N High Blood Pressure	Y N Sinus Problems
Y N Asthma	Y N HIV + AIDS	<u>Allergies</u>
Y N Blood Transfusion	Y N Kidney Problems	Y N Aspirin
Y N Cancer -Chemotherapy	Y N Liver Disease	Y N Codeine
Y N Colitis	Y N Low Blood Disease	Y N Dental Anesthetics
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Erythromycin
Y N Cosmetic Surgery	Y N Pace Maker	Y N Jewelry
Y N Diabetes	Y N Pneumocystitis	Y N Latex
Y N Difficulty Breathing	Y N Psychiatric Problems	Y N Metals
Y N Drug abuse	Y N Radiation Therapy	Y N Penicillin
Y N Emphysema	Y N Rheumatic Fever	Y N Tetracycline
Y N Epilepsy	Y N Seizures	Other: _____
Y N Fainting Spells	Y N Shingles	_____
Y N Fever Blisters	Y N Sickle Cell Disease	_____
Y N Frequent Headaches	Y N Pins	

Do you have or have you had any disease, condition or problem not listed above? Yes or No
 Explain _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I will inform the dentist and staff before the next appointment.

X _____ Date _____
 Patient or responsible party signature

FOR OFFICE USE: Reviewed by _____ Date _____

Date **Changes** **Patient or Guardian Signature**
