DENTAL HISTORY

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING	[ ]	[ ]
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS OR FOODS?	[ ]	[ ]
HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	[ ]	[ ]
DO YOU CLENCH OR GRIND YOUR TEETH?	[ ]	[ ]
HAVE YOU EVER HAD DIFFICULT EXTRACTIONS IN THE PAST?	[ ]	[ ]
HAVE YOU EVER HAD PROLONGED BLEEDING AFTER EXTRACTIONS?	[ ]	[ ]
HAVE YOU EVER HAD ANY OF THE FOLLOWING?		
-DIFFICULTY IN OPENING OR CLOSING?	[ ]	[ ]
-DIFFICULTY IN CHEWING?	[ ]	[ ]
-CLICKING?	[ ]	[ ]
-PAIN: JOINT, EAR, SIDE OF FACE?	[ ]	[ ]

	YES	NO
ARE YOUR TEETH SENSITIVE TO HOT OR COLD?	[ ]	[ ]
DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	[ ]	[ ]
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	[ ]	[ ]
DO YOU HAVE FREQUENT HEADACHES?	[ ]	[ ]
DO YOU BITE YOUR LIPS / CHEEKS FREQUENTLY?	[ ]	[ ]
HAVE YOU EVER HAD BRACES?	[ ]	[ ]
HAVE YOU EVER HAD INSTRUCTIONS ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	[ ]	[ ]
HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	[ ]	[ ]
DO YOU USE TOBACCO? HOW MUCH?__________	[ ]	[ ]
DO YOU CONSUME ALCOHOL?	[ ]	[ ]
DO YOU USE MARIJUANA, COCAINE, OTHER?________	[ ]	[ ]
ARE YOU WEARING CONTACT LENSES?	[ ]	[ ]
DO YOU HAVE DENTAL EXAMS ON A REGULAR BASIS?	[ ]	[ ]

DATE OF LAST DENTAL CLEANING?__________________

MEDICAL HISTORY

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

[ ] HEART TROUBLE
[ ] HIGH BLOOD PRESSURE
[ ] LOW BLOOD PRESSURE
[ ] HEART MURMUR
[ ] RHEUMATIC FEVER
[ ] CONGENITAL HEART LESION
[ ] NERVOUSNESS
[ ] HEART PACEMAKER
[ ] HEART SURGERY
[ ] BLOOD DISEASE
[ ] ANEMIA
[ ] YELLOW JAUNDICE
[ ] CHEST PAINS
[ ] SHORTNESS OF BREATH
[ ] SWELLING OF FEET / ANKLES
[ ] FAINTING / DIZZINESS
[ ] STROKE
[ ] DIABETES
[ ] EXCESSIVE THIRST

[ ] SCARLET FEVER
[ ] ASTHMA
[ ] HAY FEVER
[ ] SINUS TROUBLES
[ ] EMPHYSEMA
[ ] FREQUENT COUGH
[ ] LUNG DISEASE
[ ] TUBERCULOSIS
[ ] LIVER DISEASE
[ ] HEPATITIS A (INFEC)
[ ] HEPATITIS B (SERUM)
[ ] CANCER
[ ] THYROID DISEASE
[ ] PARATHYROID DISEASE
[ ] CHEMO / RADIATION
[ ] ARTHRITIS / GOUT
[ ] RHEUMATISM
[ ] CORTISONE MEDICINE

[ ] HIV / AIDS
[ ] VENEREAL DISEASE
[ ] COLD SORES
[ ] FEVER BLISTERS
[ ] HERPES
[ ] BRUISE EASILY
[ ] SICKLE CELL ANEMIA
[ ] HEMOPHILIA
[ ] ARTIFICIAL HEART VALVE
[ ] ALLERGIES
[ ] DRUG ADDICTION
[ ] STOMACH TROUBLES / ULCERS
[ ] PSYCHIATRIC CARE
[ ] ARTIFICIAL JOINTS / HIPS
[ ] HYPOGLYCEMIA
[ ] EPILEPSY / SEIZURES
[ ] JOINT REPLACEMENT / IMPLANT
[ ] GLAUCOMA

MEDICAL DOCTOR'S NAME AND PHONE NUMBER:______________________________

	YES	NO
ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? EXPLAIN:______________	[ ]	[ ]
HAVE YOU BEEN HOSPITALIZED IN THE PAST TWO YEARS? EXPLAIN:______________	[ ]	[ ]
ARE YOU TAKING ANY MEDICATIONS? LIST:______________	[ ]	[ ]
ARE YOU ALLERGIC TO ANY MEDICATIONS? LIST:______________	[ ]	[ ]
ARE YOU PREGNANT? HOW MANY MONTHS?______________	[ ]	[ ]
DO YOU WISH TO TALK PRIVATELY ABOUT ANY PROBLEM?______________	[ ]	[ ]
HAVE YOU HAD ANY OTHER SERIOUS ILLNESS NOT LISTED ABOVE?______________	[ ]	[ ]

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

______________________________ PATIENT (PARENT/ GUARDIAN)   ______________ DATE

______________________________ REVIEWED BY: ______________ DATE