GENERAL HEALTH INFORMATION

PATIENT NAME _____ **BIRTHDATE** _____
Last **First**

DENTAL HISTORY

1. Reason for visit/Main concern: ☐ Check-up ☐ Cleaning ☐ Toothache ☐ Other: _____

2. Are there other conditions of which we should be aware? ☐ Yes ☐ No If yes, please specify: _____

3. When did you last visit a dentist? _____ 4. What treatment was performed? _____

5. Was the treatment completed? _____ 6. When were dental x-rays taken? _____

7. Did you have a cleaning? ☐ Yes ☐ NO 8. Have you had gum (periodontal) treatment? ☐ Yes ☐ NO
9. Have you ever had prolonged bleeding after an extraction? ☐ Yes ☐ NO If yes, please specify: _____
10. Have you had any problems with past dental treatment? ☐ Yes ☐ NO If yes, please specify: _____
11. Do you grind your teeth, clinch your jaws, or have symptons near your ears such as clicking, popping, pain, or locking open?
☐ Yes ☐ NO If yes, please specify:
_____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) Sometimes called TMJ?
☐ Yes ☐ NO If yes, please specify: _____
13. Do your gums bleed easily? ☐ Yes ☐ NO 14. Do you feel you have bad breath? ☐ Yes ☐ NO
15. Are your teeth sensitive to hot or cold? ☐ Yes ☐ NO 16. Would you like your teeth whiter? ☐ Yes ☐ NO

17. Are you happy with your smile? ☐ Yes ☐ NO If no, please explain: _____

MEDICAL HISTORY

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

Artificial heart valve	Yes ☐	NO ☐	Epilepsy	Yes ☐	NO ☐	Low BP	Yes ☐	NO ☐
AIDS/HIV+	Yes ☐	NO ☐	Fainting	Yes ☐	NO ☐	Lung Disease	Yes ☐	NO ☐
Anemia	Yes ☐	NO ☐	Glaucoma	Yes ☐	NO ☐	Pacemaker	Yes ☐	NO ☐
Angina	Yes ☐	NO ☐	Heart Attack	Yes ☐	NO ☐	PHEN-FEN	Yes ☐	NO ☐
Arthritis	Yes ☐	NO ☐	Heart Surgery	Yes ☐	NO ☐	Psychiatric Care	Yes ☐	NO ☐
Asthma	Yes ☐	NO ☐	Heart Murmer	Yes ☐	NO ☐	Rheumatic Fever	Yes ☐	NO ☐
Bleeding Problems	Yes ☐	NO ☐	Heart Problems	Yes ☐	NO ☐	Sinus Trouble	Yes ☐	NO ☐
Cancer	Yes ☐	NO ☐	Hepatitis	Yes ☐	NO ☐	Smoking Tobacco	Yes ☐	NO ☐
Chemo/Rad Therapy	Yes ☐	NO ☐	High BP	Yes ☐	NO ☐	Stroke	Yes ☐	NO ☐
Cosmetic Surgery	Yes ☐	NO ☐	Jaundice	Yes ☐	NO ☐	Thyroid Problems	Yes ☐	NO ☐
Diabetes	Yes ☐	NO ☐	Joint Replacement	Yes ☐	NO ☐	TMD or TMJ	Yes ☐	NO ☐
Dizzy Spells	Yes ☐	NO ☐	Kidney Disease	Yes ☐	NO ☐	Tuberculosis	Yes ☐	NO ☐
Drug Addiction	Yes ☐	NO ☐	Latex Allergy	Yes ☐	NO ☐	Venereal Disease		
Emphysema	Yes ☐	NO ☐	Liver 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 taking x-rays and an oral examination.

Patient's Signature_____Doctor's Signature_____Date_____
(Parent is patient is a minor)

MEDICAL UPDATE:

Patient's Signature _____ Doctor's Signature_____Date_____

Patient's Signature _____ Doctor's Signature_____Date_____

Patient's Signature _____ Doctor's Signature_____Date_____