AIDS/HIV	☐	YES	☐	NO	HEPATITIS TYPE ____	☐	YES	☐ NO
ANEMIA	☐	YES	☐	NO	HERPES	☐	YES	☐ NO
ARTHRITIS	☐	YES	☐	NO	HIGH BLOOD PRESSURE	☐	YES	☐ NO
ARTIFICIAL HEART VALVES	☐	YES	☐	NO	HIVES OR SKIN RASH	☐	YES	☐ NO
ASTHMA	☐	YES	☐	NO	JAUNDICE	☐	YES	☐ NO
BLEEDING ABNORMALLY	☐	YES	☐	NO	KIDNEY DISEASE	☐	YES	☐ NO
BLOOD DISORDER	☐	YES	☐	NO	LIVER DISEASE	☐	YES	☐ NO
CANCER	☐	YES	☐	NO	LOW BLOOD PRESSURE	☐	YES	☐ NO
CHEMICAL DEPENDENCY	☐	YES	☐	NO	MENTAL OR NERVOUS PROBLEMS	☐	YES	☐ NO
CHEMOTHERAPY	☐	YES	☐	NO	RADIATION TREATMENT	☐	YES	☐ NO
CONGENITAL HEART DISEASE	☐	YES	☐	NO	RESPIRATORY DISEASE	☐	YES	☐ NO
COUGH	☐	YES	☐	NO	RHEUMATIC FEVER	☐	YES	☐ NO
DIABETES	☐	YES	☐	NO	SHORTNESS OF BREATH	☐	YES	☐ NO
EMPHYSEMA	☐	YES	☐	NO	SINUS TROUBLE	☐	YES	☐ NO
EPILEPSY	☐	YES	☐	NO	STOMACH ULCER	☐	YES	☐ NO
FAINTING OR DIZZINESS	☐	YES	☐	NO	STROKE	☐	YES	☐ NO
GASTRO-INTESTINAL DISEASE	☐	YES	☐	NO	SWOLLEN FEET OR ANKLES	☐	YES	☐ NO
GLAUCOMA	☐	YES	☐	NO	SWOLLEN NECK GLANDS	☐	YES	☐ NO
HAY FEVER	☐	YES	☐	NO	THYROID PROBLEMS	☐	YES	☐ NO
HEADACHES	☐	YES	☐	NO	TUBERCULOSIS	☐	YES	☐ NO
HEART MURMUR	☐	YES	☐	NO	TUMORS	☐	YES	☐ NO
HEART DISEASE	☐	YES	☐	NO	VENEREAL DISEASE	☐	YES	☐ NO

Are you allergic to any of the following?

Penicillin	☐	Valium	☐	Codeine	☐
Erythromycin	☐	Latex	☐	Sulfa	☐
Tetracycline	☐	Aspirin	☐	Local Anesthetic	☐

Please list any other allergies _____
Please list any medications you are currently taking: _____
_____

Women: Are you currently pregnant? YES_____ NO_____
Is there any history of family disease? If yes, please describe _____
Do you use tobacco? YES_____ NO_____
Are you frequently under stress? YES_____ NO_____
Do you find yourself clenching or grinding your teeth? YES_____ NO_____
Do you have aches in the jaw joint, face muscles? YES_____ NO_____
Are you aware of your jaws clicking or popping while eating or sleeping? YES_____ NO_____
Do you have difficulty in opening your mouth widely? YES_____ NO_____
Are you a mouth breather? YES_____ NO_____
Have you had orthodontic work (braces)? YES_____ NO_____
Have you had previous periodontal treatment (gum surgery)? YES_____ NO_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
Signature of Patient, Parent, or Guardian_____ Date_____