It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

* DENTAL HISTORY *

	YES	NO
How LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam Date:		
Last FULL MOUTH X-RAYS, Date: (Machine that rotates around your head, or 16 small films)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Have you had BAD dental experiences in the past?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)		
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Do you have LOOSE, TIPPED, or SHIFTING teeth? (Circle)		
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you have problems with teeth/fillings BREAKING?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	☐	☐

Name of Previous Dentist: _____

City _____ State: _____

How do you feel about your teeth? _____

* MEDICAL HISTORY *

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIANS CARE now?	☐	☐
For what?		
Are you currently taking any medication?	☐	☐
If yes, What?		

Circle any of the following that you have had or have at present:

A.I.D.S./HIV	Epilepsy or Seizures	Pigment Lesions in Mouth or on Body
Allergies or Hives	Fainting or Dizzy Spells	Pneumocystitis
Anemia	Fever Blisters	Psychiatric Treatment
Angina Pectoris	Glaucoma	Rheumatic Fever
A.R.C.	Hay Fever	Rheumatism
Arthritis	Heart Disease or Attack	Scarlet Fever
Artificial Heart Valve	Heart Failure	Sickle Cell Disease
Artificial Joints (Hip, Knee)	Heart Murmur	Sinus Trouble
Asthma	Heart Pacemaker	Stroke
Blood Thinners	Heart Surgery	Thyroid Disease
Blood Transfusion	Hemophilia	Tuberculosis (TB)
Bruise Easily	Hepatitis A (infectious)	Ulcers
Chemotherapy (Cancer, Leukemia)	Hepatitis B (serum)	Unexplained Weight Loss
Congenital Heart Lesions	High Blood Pressure	Venereal Disease (Syphilis, Gonorrhea, etc.)
Cortisone Medicine	Kidney Trouble	X-ray or Cobalt Treatment
Cosmetic Surgery	Liver Disease	Yellow Jaundice
Diabetes	Mitral Valve Prolapse	Tattoos
Drug Addiction	Nervousness	Piercings
Emphysema	Night Sweats, Fever	
	Pain in Jaw Joints	

Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Latex	Other
Codeine	*Sulfa*	*Penicillin*
Darvon	Local Anesthetic	Percodan
Erythromycin	Nitrous Oxide	Valium

Are you aware of being allergic to any other medication or substances?

If yes, please list _____

Have you ever been told to be pre-medicated for any dental procedure?

FAMILY PHYSICIAN: _____ PHONE No. _____

Is there any other Medical or Dental Information that you feel I should know about?

_____

BLOOD PRESSURE READING _____

Date	Medical Changes	Int.	Date	Medical Changes	Int.