

Medical History

Do you have a physician? Yes No Their name: _____ Their phone: _____ Date of last doctor's appt: _____ Your current physical health is: Good Fair Poor Are you currently under the care of any physician? Yes No If yes, please explain: _____ _____ Do you smoke or use tobacco in any form? Yes No Are you presently taking any drugs prescribed by a physician or dentist? Yes No If yes, please list: _____ For women: Are you pregnant? No Yes Week #: _____ Have you had any serious medical problems in the last 5 years? No Yes If yes, please explain: _____ _____ _____	Have you ever had any of the following diseases or medical problems? Y N Heart Attack / Stroke Y N Heart Murmur / Rheumatic Fever Y N Heart Surgery / Pacemaker Y N Chronic Hepatitis Y N Anemia Y N High / Low Blood Pressure Y N Severe Headaches Y N Epilepsy / Seizures / Fainting Y N Drug / Alcohol Abuse Y N Hemophilia / Abnormal Bleeding Y N Cancer / Chemotherapy Y N HIV + / Aids Y N Shingles Y N Kidney Problems Y N Sinus Problems Y N Fever Blisters Y N Psychiatric Problems Y N Diabetes Y N Tuberculosis Y N Sickle Cell Disease
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Are you allergic to any of the following? Penicillin Tetracycline Aspirin Codeine Erythromycin Dental Anesthetic
 Please list any other drugs you are allergic to: _____

Dental History

Why have you come to the dentist today? _____

Do you want to save your teeth?	Yes	No
Are you having any dental pain now?	Yes	No
Do you have any pain from hot, cold, or sweets?	Yes	No
Are any teeth tender to touch or percussions?	Yes	No
Do you have any pain when you bite or chew?	Yes	No
Do your jaws click / make noise when you yawn or open wide?	Yes	No
Do you grind or clench your teeth?	Yes	No
Have you ever had orthodontics?	Yes	No
Do you chew on both sides of your mouth?	Yes	No
Do your gums bleed?	Yes	No
How often do you brush? _____ Vigorously / Lightly		
What kind of brush do you use? Hard Medium Soft		
Do you do anything else for your oral hygiene?	Yes	No
If yes, what else? _____		
Have you ever had professional instruction in home care?	Yes	No
When was your last dental visit? _____		
What was done at that time? _____		