MEDICAL HISTORY (PLEASE CIRCLE YES OR NO)

1. Has there been a recent change in your heath? .... No Yes
   If yes, please explain:______
2. When was your last physical examination? .... ______
3. Are you under the care of a physician? .... No Yes
4. Have you been hospitalized or had a serious illness within the last five years? .... No Yes
5. Do you have or have you had any of the following (Please check appropriate conditions)

Heart:

- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ High/Low Blood Pressure
- ☐ Heart Value Replacement
- ☐ Mitral Value Prolapse
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Angina
- ☐ Heart Operation
- ☐ Abnormal Bleeding/Blood Disorder

Other:

- ☐ Asthma or Hay Fever
- ☐ Fainting Spells or Seizures
- ☐ Tuberculosis
- ☐ Radiation Therapy
- ☐ Diabetes
- ☐ Hepatitis (A or B)
- ☐ Jaundice or Liver Disease
- ☐ Arthritis or Rheumatism
- ☐ Kidney Problems
- ☐ Venereal Disease
- ☐ Artificial Joint Replacement
- ☐ Auto-Immune Deficiency Syndrome
- ☐ Stroke
- ☐ Other .... No Yes

6. Do you have any disease, condition or other problems not listed above that you think I should know about .... No Yes
7. Do you have difficulty breathing through your nose? .... No Yes
8. Are you allergic to any drugs or medications such as Penicillin, Codeine or Aspirin? .... No Yes
   If yes, what?______
9. List any medication(s) you are currently taking: ______
   ______
10. Are you aware of any lumps in your mouth? .... No Yes

WOMEN ONLY

1. Are you pregnant? If so, how many months? ______
2. Are you taking birth control pills? .... No Yes

DENTAL HISTORY

1. Are you aware of any dental problems at this time? .... No Yes
2. When was your last dental visit? ______
   What was performed? ______
3. Are you seen in a dental office on a regular basis? .... Yes No
4. Have you had a full set of full mouth x-rays (18 pictures) in the last 3 years? .... No Yes
   If no, when was the last set? ______
5. Have you had a dental cleaning within the last year? .... Yes No
   If no, when was your last cleaning?______
6. Have you ever had instructions in oral hygiene technique? .... Yes No
7. How often do you brush your teeth? ______
8. Do your gums bleed? .... No Yes
9. Have you had any of the following treatment? Orthodontics, Endodontics (Root Canal), Periodontics (Gum Therapy) .... No Yes
10. Do you experience pain or clicking in your jaw, ear or facial muscles upon opening your mouth? .... No Yes
11. Are you aware of grinding or clenching your teeth? .... No Yes
12. Do you suffer anxiety or gagging during dental procedures .... No Yes
13. Are you unhappy with the appearance of your teeth? .... No Yes
    Why? ______
14. What changes would you make? ______
15. Interests and hobbies? ______

Patient's (or Guardian's) Signature:______ Date: ______

Reviewed by: ______ Date: ______

HEALTH HISTORY