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

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? YES NO

Please explain ____

____

Is your present dental health POOR? YES NO

Would you like to have NITROUS OXIDE (laughing gas) treatment? YES NO

Do your gums BLEED, or feel TENDER or IRRITATED? YES NO

Are your teeth sensitive to HOT, COLD, SWEETS, PRESSURE? (circle) YES NO

Are you UNHAPPY with the APPEARANCE of your teeth? YES NO

Color? YES NO

Shape? YES NO

Do you have LOOSE, TIPPED, or SHIFTING teeth? (Circle) YES NO

Name of previous Dentist: ______________________________

City ____________________________ State __________

How you feel about your teeth? ______________________

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment...

FEAR of pain	#	LACK of concern	#
COST of treatment	#	MISSING work time	#

Whom may we thank for referring you to our office? ______________________________________

MEDICAL HISTORY

PHYSICIANS NAME ______________________________ Date of last physical exam ______________________________

Birth date ______________________________ Age ______________________________

Do you have or have you had any of the following? Please indicate with checkmark.

- ○ Any heart problems
- ○ High blood pressure
- ○ Low blood pressure
- ○ Circulatory problems
- ○ Nervous problems
- ○ Radiation treatments
- ○ Excessive bleeding
- ○ AIDS
- ○ HIV-positive
- ○ Allergies to anesthetics
- ○ Allergies to medicines or drugs
- ○ Allergies to: _______________
- ○ Anemia
- ○ Arthritis
- ○ Asthma
- ○ Diabetes
- ○ Hepatitis
- ○ Herpes
- ○ Malignancies
- ○ Measles
- ○ Mumps
- ○ Psychiatric care
- ○ Rheumatic Fever
- ○ Scarlet Fever
- ○ Sinus Problems
- ○ Stroke
- ○ Typhoid fever
- ○ Tonsillitis
- ○ Tuberculosis
- ○ Ulcer
- ○ Venereal Disease

Are you pregnant? YES NO   Blood pressure: S__________ /D__________/__________

Please describe any medical treatment, impending operations or any other medical or dental information that may possibly affect your dental treatment:

____

Names Of Drugs Allergic To: ____

____

Medication Taking Now: ____

____

Date ______________________________ Your signature ______________________________