Date ______________________

Name ______________________ Date of Birth ______________________

Address ______________________ Telephone (home) ______________________

Employer ______________________ Telephone (work) ______________________

Employer's Address ______________________

Social Security Number ______________________ Parent or Spouses Name ______________________

PATIENT MEDICAL HISTORY

Physician ______________________ Phone Number ______________ Date of last physical exam ______________

		Yes	No
1.	Are you under any medical treatment now?	☐	☐
2.	What medications are you currently taking ______________________		
3.	Have you had any major operations? if so what?	☐	☐
4.	Have you ever had a serious accident involving head injuries?	☐	☐
5.	Have you ever had any adverse response to any drugs?	☐	☐
6.	Has a physician ever informed you that you had: A Heart Ailment?	☐	☐
7.	High Blood Pressure?	☐	☐
8.	Respiratory Disease?	☐	☐
9.	Diabetes?	☐	☐
10.	Rheumatic Fever?	☐	☐
11.	Rheumatism or Arthritis?	☐	☐
12.	Tumors or Growths?	☐	☐
13.	Any Blood Disease?	☐	☐
14.	Any Liver Disease?	☐	☐
15.	Any Kidney Disease?	☐	☐
16.	Any Stomach or Intestinal Disease?	☐	☐
17.	Any Venereal Disease?	☐	☐
18.	Yellow Jaundice or Hepatitis?	☐	☐
19.	Do you have night sweats accompanied by weight loss or cough?	☐	☐
20.	Are you on a diet at this time?	☐	☐
21.	Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?	☐	☐
22.	Are you in general good health at this time?	☐	☐
23.	Have any wounds healed slowly or presented any other complications?	☐	☐
24.	Are you pregnant?	☐	☐
25.	Do you have a history of fainting?	☐	☐
26.	Have you ever had any **Radiation Therapy**?	☐	☐

PATIENT DENTAL HISTORY

		Yes	No
27.	Do you have pain in or near your ears?	☐	☐
28.	Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
29.	Does any part of your mouth hurt when clenched?	☐	☐
30.	Have you experienced any growth or sore spots in your mouth?	☐	☐
31.	Have you ever had Novicaine anesthetic?	☐	☐
32.	Any reactions or allergic symptoms to novicane?	☐	☐
33.	Any difficult extractions in the past?	☐	☐
34.	Prolonged bleeding following extractions in the past?	☐	☐
35.	Trench Mouth?	☐	☐
36.	Do your gums bleed?	☐	☐
37.	Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
38.	Have you ever had instructions on the care of your gums?	☐	☐
39.	Do you chew on only one side of your mouth? If so why?	☐	☐
40.	Do you at the present time have any dental complaints?	☐	☐
41.	Do you habitually clench you teeth during the night or day?	☐	☐
42.	When was your last full mouth x-ray taken? ______________ Where? ______________		
43.	Any part of your mouth sore to pressures or irritants (cold, sweets, etc.) If so locate ______________	☐	☐

Signature ______________________ Dr. Signature ______________________

(Parents' Signature if patient is under 18 year of age)