

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

Last COMPLETE Dental Exam, Date: _____ Color? YES NO

Last FULL MOUTH X-RAYS, DATE: _____ Shape? YES NO
(machine that rotates around your head, or 16 small films.) _____

Are you having PROBLEMS now? YES NO Do you have LOOSE, TIPPED, or SHIFTING teeth? (Circle) YES NO

Please explain _____ Name of previous Dentist: _____

City _____ State _____

Is your present dental health POOR? YES NO How you feel about your teeth? _____

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

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 _____