PERSONAL MEDICAL HISTORY

General health (Please circle): Excellent Good Fair Poor
Have there been any recent changes in your general health? Yes No

Please explain: _____

Name and address of physician _____
Date of last complete physical _____

Are you taking any medication now? Yes No

If so, for what purpose? _____

What is your usual blood pressure? _____/_____

Have you ever been diagnosed or treated for: (Circle if yes)

Heart Disease	Epilepsy	Shortness of Breath
Rheumatic Fever	Anemia	Hemophilia
Abnormal Blood Pressure	Heart Pacemaker	Chemotherapy
Congenital Heart Lesion	Cancer	Sinus Trouble
Scarlet Fever	Thyroid Problems	Persistent Cough
Artificial Heart Valve	Prolonged Bleeding	Hepatitis A Infectious
Mitral Valve Prolapse	Fainting	Hepatitis B Serum
Heart Surgery	Heart Murmur	Arthritis
Artificial Joint	Jaundice	Stroke
Vascular Surgery	Asthma or Hay Fever	Venereal Disease
Ulcers	Glaucoma	HIV Positive, AIDs
Tuberculosis	Drug or Alcohol Abuse	Herpes
Diabetes	Kidney Disorders	Human Papiloma Virus
Cold Sores		

Have you been treated with radiation? Yes No

Are you allergic to: Penicillin, Codeine, Local Anesthesia (Novocaine),
Other medication, metal, latex/rubber

Do you have excess urination or thrist? Yes No
Do you use recreational drugs? Yes No
(Women) Are you pregnant? Yes No Due Date: _____
Do you take birth control pills or hormone therapy? Yes No
Have you been treated with drugs for osteoporosis? Yes No

Please add any further information about your medical health
_____
_____

To the best of my knowledge, the above is true and correct.
(Signed) _____

Personal Oral Health

When was your last dental visit? _____
Have you ever had any serious problem associated with previous dental treatment?
Yes No
If so, explain. _____
_____

Do you usually have many cavities? Yes No
Do you believe you will keep your teeth for your lifetime? Yes No
Does the sound of dental treatment annoy you? Yes No
Are you concerned about Dental anesthetic infection? Yes No
Are you pleased with the appearance of your smile? Yes No
Is the color of your teeth acceptable to you? Yes No
Are you interested in cosmetic dental treatment? Yes No
Do you wish to have any missing teeth replaced? Yes No
Do you breathe through your mouth most of the time? Yes No
Do you feel pain when your teeth come in contact with:
Hot foods or liquids Yes No
Cold foods or liquids Yes No
Air, floss Yes No
Do you feel pain in any of your teeth when brushing? Yes No
Where? _____
Do you have a bad taste or mouth odor? Yes No
Do your gums feel tender or swollen? Yes No
Do your gums bleed when brushing or flossing? Yes No
Do you clench or grind your teeth? Yes No
While sleeping? Yes No
Do your jaws ever feel tired or have earaches? Yes No
Do your jaw joints make sounds or hurt when you open? Yes No
Does food easily wedge between certain teeth? Yes No
Do you gag easily? Yes No
How often do you brush your teeth? Once Twice Three…per day
What texture brush do you use? Soft Medium Hard
How often do you floss? Once per day or, _____ times per week
Do you rinse with a fluoridated mouthwash? Yes No
Do you use any other aids in cleaning your mouth? Yes No
Do you use any other aids in cleaning your mouth? Yes No
What? _____
Do you eat or drink the following daily:
Soft drinks Candy Mints Cookies Cake Chewing gum Coffee Tea
Do you add table sugar frequently? Yes No
Do you usually eat breakfast? Yes No
Do you take vitamin supplements? Yes No
Please add anything you feel is important: _____
_____