Patient Name: _____ **Date of Birth:** _____

D E N T A L H I S T O R Y

1. Are you in pain? yes no If yes, where? _____
2. Do you have any sores or blisters on your gums, cheek or lips? yes no
3. Do you sometimes have a bad taste or bad odor from your mouth? yes no
4. Have you had orthodontics or braces to straighten your teeth? yes no
5. How would you rate your oral health? (please circle) poor fair good excellent
6. When was your last dental cleaning? _____
7. Do your teeth feel loose or mobile? yes no Do you feel your teeth have drifted or moved? yes no
8. Do you have any reactions or problems with local anesthesia (Novocaine or freezing)? yes no
9. Have you been treated for gum disease before? _____ yes no

M E D I C A L H I S T O R Y

1. Are you currently under the care or supervision of a physician? yes no
2. Date of last physical (medical examination)? _____
3. Were blood tests done? yes no Any abnormal findings? yes no
   If yes, please explain: _____
4. Is there a family history of diabetes? yes no
5. Do you smoke? yes no If yes, how much per day? _____
6. Do you have any problems with bleeding or healing after a cut or surgery? yes no
7. Please indicate which of the following you have, or have had in the past (please circle yes or no to each item).

Heart (Disease, Surgery, Attack)	yes	no	Ulcers	yes	no	Dry Mouth / Sjögren's	yes	no
Chest Pain, Angina	yes	no	Diabetes	yes	no	Hepatitis A, B, or C	yes	no
Congenital Heart Disease	yes	no	Thyroid Problems	yes	no	Venereal Disease	yes	no
High Blood Pressure	yes	no	Glaucoma	yes	no	HIV / A.I.D.S.	yes	no
Heart Murmur	yes	no	Contact Lenses	yes	no	Blood Transfusion	yes	no
Mitral Valve Prolapse	yes	no	Emphysema	yes	no	Hemophilia	yes	no
Artificial Heart Valve	yes	no	Chronic Cough	yes	no	Sickle Cell Disease	yes	no
Heart Pacemaker	yes	no	Tuberculosis	yes	no	Bruise Easily	yes	no
Rheumatic Fever	yes	no	Asthma	yes	no	Liver Disease	yes	no
Artificial Joint (hip, knee, etc.)	yes	no	Hay Fever	yes	no	Yellow Jaundice	yes	no
Cortisone, Steroid Medicine	yes	no	Latex Sensitivity	yes	no	Neurological Disorder	yes	no
Swollen Ankles	yes	no	Allergies	yes	no	Epilepsy or Seizures	yes	no
Stroke	yes	no	Sinus Trouble	yes	no	Fainting/Dizzy Spells	yes	no
Diet (special/restricted)	yes	no	Chemotherapy	yes	no	Nervous/Anxious	yes	no
Arthritis, Rheumatism	yes	no	Radiation Therapy	yes	no	Cold Sores	yes	no
Kidney Trouble	yes	no	Cancer / Tumors	yes	no	Psychiatric care	yes	no

Other (not listed above): _____

9. Women: Pregnant? yes (___ months) no Nursing? yes no Taking Birth Control Pills? yes no
10. Have you ever taken Fosamax, Boniva, or Actonel (medicine for osteoporosis)? yes no
11. Do you have allergies (or adverse reactions) to any medication or substances? yes no
    If yes please explain: _____
12. Are you using blood thinners (coumadin, plavix)? yes no Do you take aspirin regularly? yes no
13. Are you taking any other medication(s)? yes no
    If yes please list name(s) and dosage(s): _____
    _____
14. Are you taking any herbal supplements? yes no
    If yes please list name(s) and dosage(s): _____

I have completed this health questionnaire to the best of my ability. I understand that the above information is necessary to provide safe and effective dental care. I give permission to discuss with other health care providers my dental and medical treatment should further information be needed. I give permission to take pictures to be aid in my care or be used for educational purposes. I will notify the office of any change in my health or medicine.

Patient Signature: Date: