GENERAL HEALTH INFORMATION

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

DENTAL HISTORY

1. **Reason for Visit / Main Concern**? Check-Up ☐ Cleaning ☐ Toothache ☐ Other _____
2. Are there other conditions of which we should be aware? YES ○ NO ○ If yes, please specify: _____
3. When did you last visit a dentist? _____
4. What treatment was performed? _____
5. Was the treatment completed? _____
6. When were dental x-rays taken? _____
7. Did you have a cleaning ? YES ○ NO ○
8. Have you had gum (periodontal) treatment? YES ○ NO ○
9. Have you ever had prolonged bleeding after an extraction? YES ○ NO ○ If yes, please specify: _____
10. Have you had any problems with past dental treatment? YES ○ NO ○ If yes, please specify: _____
11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES ○ NO ○ If yes, please specify: _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES ○ NO ○ If yes, please specify: _____
13. Do your gums bleed easily? YES ○ NO ○
14. Do you feel you have bad breath? YES ○ NO ○
15. Are your teeth sensitive to hot or cold? YES ○ NO ○
16. Would you like your teeth whiter? YES ○ NO ○
17. Are you happy with your smile? YES ○ NO ○ If no, please explain: _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES ○ NO ○ If yes, please specify: _____ Dr. Name: _____
   Dr. Phone: ( ) _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES ○ NO ○ If yes, please specify: _____
4. (Women) Are you pregnant now? YES ○ NO ○ If yes, how many months? _____ Are you nursing? YES ○ NO ○
5. Are there any other health problems of which we should be advised? Please specify: _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"

ARTIFICIAL HEART VALVE	YES ○	NO ○
AIDS/HIV+	YES ○	NO ○
ANEMIA	YES ○	NO ○
ANGINA	YES ○	NO ○
ARTHRITIS	YES ○	NO ○
ASTHMA	YES ○	NO ○
BISPHOSPHONATE THERAPY	YES ○	NO ○
BLEEDING PROBLEMS	YES ○	NO ○
CANCER	YES ○	NO ○
CHEMO/RAD THERAPY	YES ○	NO ○
COSMETIC SURGERY	YES ○	NO ○
DIABETES	YES ○	NO ○
DIZZY SPELLS	YES ○	NO ○
DRUG ADDICTION	YES ○	NO ○
EMPHYSEMA	YES ○	NO ○
EPILEPSY	YES ○	NO ○
FAINTING	YES ○	NO ○
GLAUCOMA	YES ○	NO ○
HEART ATTACK/SURGERY	YES ○	NO ○
HEART MURMUR/PROBLEMS	YES ○	NO ○

Please check "YES" or "NO"

HEPATITIS	YES ○	NO ○
HIGH BL. PRESSURE	YES ○	NO ○
JAUNDICE	YES ○	NO ○
JOINT REPLACEMENT	YES ○	NO ○
KIDNEY DISEASE	YES ○	NO ○
LATEX ALLERGY	YES ○	NO ○
LIVER PROBLEMS	YES ○	NO ○
LOW BL. PRESSURE	YES ○	NO ○
LUNG DISEASE	YES ○	NO ○
PACEMAKER	YES ○	NO ○
PSYCHIATRIC CARE	YES ○	NO ○
RHEUMATIC FEVER	YES ○	NO ○
SINUS TROUBLE	YES ○	NO ○
SLEEP APNEA	YES ○	NO ○
TOBACCO	YES ○	NO ○
STROKE	YES ○	NO ○
THYROID PROBLEMS	YES ○	NO ○
TMD OR TMJ	YES ○	NO ○
TUBERCULOSIS	YES ○	NO ○
VENEREAL DISEASE	YES ○	NO ○

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature _____ Date _____
(Parent if Patient is a Minor)

Doctor Signature _____

Pharmacy Name: _____

(COMPLETE BOTH SIDES)