MEDICAL HISTORY

GENERAL HEALTH (Please circle one) Excellent Good Fair Poor

NAME AND ADDRESS OF PHYSICIAN:

____

LAST COMPLETE PHYSICAL ____

ARE YOU TAKING ANY MEDICATION NOW? YES____ NO ____ PLEASE LIST ________________________

HAVE YOU BEEN TREATED FOR: (Please Check)

___ Heart Disease
___ Rheumatic Fever
___ Abnormal Blood Pressure or Problems
___ Tuberculosis or Lung Disease
___ Diabetes
___ Epilepsy
___ Anemia
___ Congenital Heart Disease
___ Heart Murmur
___ Jaundice
___ Asthma or Hay Fever
___ Sinus Trouble
___ Hepatitis
___ Arthritis
___ Stroke
___ HIV/AIDS
___ Cancer

Are you Allergic to: Penicillin ___ Codeine ___ Local Anesthetics ___ Other Medications ________________________

Are you subject to prolonged bleeding ....YES___ NO___

Are you subject to fainting spells ....YES___ NO___

Do you have frequent headaches ....YES___ NO___

Do your jaws pop or click..YES___ NO___

Do your jaws feel tired ....YES___ NO___

Do you clench or grind your teeth ....YES___ NO___

(Women) Are you pregnant..YES___ NO___

What is the reason for this visit?____

Please add anything that you feel is important ____

DENTAL HEALTH

Have you ever had any serious problem associated with previous dental treatment? YES___ NO___

When did you have your last cleaning?____________________

How often do you brush?____________________________

What texture brush do you use? (soft, medium, hard, natural) __________________ Brand? ______________________

How often do you floss? ______________________________________

Do your gums bleed when brushing and/or flossing?__________________

Do you avoid brushing any part of your mouth because of pain?_______________

If yes, what part? ____

Do you have sensitivity when your teeth contact hot, cold or sweets?_____________________________

Do your gums feel tender or swollen? ____

Do you lose fillings or break fillings?____

Do you gag easily? ____

Please add anything you feel is important ____

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Patient/Parent Signature Date