

**GENERAL HEALTH
INFORMATION**

Date: _____

PATIENT NAME _____ **BIRTH DATE** _____ **AGE** _____
last first

DENTAL HISTORY

(circle one)

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 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 specify: _____

10 Have you had any problems with past dental treatment? YES NO if yes specify: _____

11 Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as popping, clicking, 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, explain: _____

MEDICAL HISTORY

1 Are you under a Doctor's care at this time? YES NO Dr. Name _____
 Dr. Phone: _____

2 Are you allergic to penicillin, codeine, local anesthetics, tranquilizers, latex, metals or any other drugs or medicine?
 Please Specify: _____

3 Are you taking any medications at this time, including birth control? YES NO _____

4 (Woman) Are you pregnant at this time? YES NO If yes, how many months: _____

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?
 circle yes or no circle yes or no

Artificial Heart Valve	YES	NO	Heart Problems	YES	NO
Aids/HIV+	YES	NO	High Blood Pressure	YES	NO
Anemia	YES	NO	Jaundice	YES	NO
Angina	YES	NO	Joint Replacement	YES	NO
Arthritis	YES	NO	Kidney Disease	YES	NO
Asthma	YES	NO	Latex Allergy	YES	NO
Bleeding Problems	YES	NO	Liver Problems	YES	NO
Cancer	YES	NO	Low Blood Pressure	YES	NO
Chemo/Rad Therapy	YES	NO	Lung Disease	YES	NO
Cosmetic Surgery	YES	NO	Pacemaker	YES	NO
Diabetis	YES	NO	Pyschiatric Care	YES	NO
Dizzy Spells	YES	NO	Rheumatic Fever	YES	NO
Drug Addition	YES	NO	Sinus Trouble	YES	NO
Emphysema	YES	NO	Smoking Tobacco	YES	NO
Epilepsy	YES	NO	Stoke	YES	NO
Fainting	YES	NO	Thyroid Problems	YES	NO
Glaucoma	YES	NO	TMD or TMJ	YES	NO
Heart Attack	YES	NO	Tuberculosis	YES	NO
Heart Surgery	YES	NO	Venereal Disease	YES	NO
Heart Murmur	YES	NO			

Patient Signature _____ Date _____

Medical Update

1.Patient's signature _____	Doctor Signature _____	Date _____
2.Patient's signature _____	Doctor Signature _____	Date _____
3.Patient's signature _____	Doctor Signature _____	Date _____