MEDICAL HISTORY

1. Name of Physician: _____ Address: _____
2. Phone: _____ Date of last Medical Exam: _____
3. Was everything normal at your last medical examination? YES / NO If no, please explain:
   _____
4. Are you currently under the care of a physician? YES / NO If yes, please explain:
   _____
5. Have you been hospitalized within the last 5 years? YES / NO If yes, please explain:
   _____
6. Have you had any new medication(s) prescribed in the last year? YES / NO If yes, please list:
   _____
7. Are you subject to prolonged or abnormal bleeding? YES / NO
8. Have you ever had any of the following? **Please circle all that apply:**

AIDS	Dizziness	Hepatitis	Radiation Treatment	Venereal Disease
Alcoholism	Drug Addiction	Herpes	Respiratory Problems	Codeine Allergy
Allergies_____	Emphysema	High Blood Pressure	Rheumatic Fever	Latex Allergy
_____	Epilepsy	Jaundice	Rheumatism	Penicillin Allergy
Anemia	Fainting	Kidney Disease	Sinus/Nasal Problems	ALLERGIC TO:
Arthritis	Glaucoma	Liver Disease	Stomach Problems	_____
Artificial Joint	Hay Fever	Low Blood Pressure	Stroke	
Asthma	Head Injuries	Nervous Disorders	Thyroid Trouble	**LIST CURRENT MEDS**:
Blood Disease	Headaches	Pacemaker	Tuberculosis	_____
Cancer	Heart Disease	Psychiatric Treatment	Tumors	_____
Diabetes	Heart Murmur	Pregnant/Due Date_____	Ulcers	_____

9. Do you smoke or use tobacco products? YES / NO How much? _____
10. Do you drink alcoholic beverages? YES / NO How much? _____

DENTAL HISTORY

1. Previous Dentist Info_____
2. Approximate date of last teeth cleaning _____ Last x-rays_____
3. How often do you brush your teeth? _____ Floss? _____
4. Have you ever been instructed on the proper care of your mouth? YES / NO
5. Do you like the appearance and/or color of your teeth? YES / NO
6. Do heat, cold, sweets or pressure cause pain in your mouth? YES / NO
7. Does food catch between your teeth? YES / NO
8. Do your gums bleed while brushing? YES / NO
9. Do your gums feel tender or swollen? YES / NO
10. Have you noticed any loosening of your teeth? YES / NO
11. Have you ever had:
    Periodontal Treatment? YES / NO
    Orthodontic Treatment? YES / NO
    Oral Surgery? YES / NO
    Injury to, or surgery of the head, neck, or mouth? YES / NO
    Your teeth or bite adjusted? YES / NO
    A night guard or other appliance? YES / NO
12. Have you ever experienced any of the following problems of the jaw?
    Pain (in the joint, ear, or side of face)? YES / NO
    Clicking, popping, or dislocation of the jaw? YES / NO
    Difficulty in opening or closing? YES / NO
    Difficulty in chewing? YES / NO
13. With regard to the following habits, do you:
    Clench or grind your teeth while awake or asleep? YES / NO
    Bite your lips or cheeks regularly? YES / NO
    Hold foreign objects (such as pencils, pipe, nails, etc) with your teeth or bite your fingernails? YES / NO
    Mouth breathe while awake or asleep? YES / NO
14. Do you generally tolerate dental treatment well? YES / NO

_____ _____

Signature Today's Date