



MEDICAL HISTORY

- 1. Has there been any change in your general health within the past year?.....YES NO
- 2. Do you have any of the following diseases or problems:
  - a. Rheumatic Fever or Rheumatic Heart Disease, Heart Murmur  
or Valvular Dysfunction .....YES NO
  - b. Congenital Heart Lesions, Prosthetic Valves, Mitral Valve Prolapse, etc.....YES NO
  - c. Cardiovascular Disease:
    - 1. Heart Trouble (Bacterial Endocarditis, Enlarged Heart, etc.).....YES NO
    - 2. Heart Attack .....YES NO
    - 3. Coronary Insufficiency .....YES NO
    - 4. Coronary Occlusion .....YES NO
    - 5. High Blood Pressure.....YES NO
    - 6. Low Blood Pressure .....YES NO
    - 7. Sodium Free Diet .....YES NO
    - 8. Atherosclerosis .....YES NO
    - 9. Stroke.....YES NO
    - 10. Cardiac Pacemaker.....YES NO
  - d. Allergies:
    - 1. Medications.....YES NO
    - 2. Other.....YES NO
  - e. Sinus Trouble.....YES NO
  - f. Asthma.....YES NO
  - g. Diabetes.....YES NO  
How Controlled? Diet\_\_\_ Insulin injection \_\_\_ Oral Insulin \_\_\_\_
  - h. Arthritis.....YES NO
  - i. Inflammatory Rheumatism (painful swollen joints).....YES NO
  - j. Stomach Ulcers.....YES NO
  - k. Kidney Trouble.....YES NO
  - l. Epilepsy.....YES NO
  - m. Psychiatric or Emotional Problems.....YES NO
  - n. For your safety, the safety of our staff and the safety of our other patients,  
please inform us if you have any of the following diseases:  
Tuberculosis \_\_\_\_\_ Venereal Disease \_\_\_\_\_ Aids \_\_\_\_\_  
Herpes \_\_\_\_\_ Hepatitis \_\_\_\_\_ HIV Positive \_\_\_\_\_
  - o. Cancer.....YES NO  
Radiation Therapy \_\_\_\_\_ Chemotherapy \_\_\_\_\_  
Any treatment for a tumor, growth, or other condition  
of your mouth or lips.....YES NO
- 3. Have you ever had any abnormal bleeding associated with  
extractions, surgery or trauma?.....YES NO
- 4. Do you have any blood disorders such as anemia?.....YES NO
- 5. Are you taking any drugs or medications (Prescription, Over-the Counter, or  
Natural)?.....YES NO  
If so, what? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Have you had any adverse reactions to any of the following:
- a. Local anesthetic.....YES NO
  - b. Penicillin or other antibiotics.....YES NO
  - c. Codeine or other narcotics.....YES NO
  - d. Sulpha drugs.....YES NO
  - e. Other drugs or medications.....YES NO
- If YES to adverse reaction, to what \_\_\_\_\_
7. Do you have any known latex sensitivity?.....YES NO
8. Have you had ANY type of surgically implanted device or prosthetic device such as hip, knee, heart valve, soft tissue implants (calf, breast, chin, etc.), or subcutaneous medicator?.....YES NO
9. If so, have you been advised by your physician of the need for you to be premedicated with an antibiotic before dental treatment can proceed?.....YES NO

Do you have any disease, condition or problem not listed above that you think we should know about.....YES NO

If so, please explain \_\_\_\_\_

\_\_\_\_\_

## DENTAL HISTORY

1. When was the date of your last dental visit? \_\_\_\_\_
2. What work was completed at that time? \_\_\_\_\_
3. On a scale of 1 to 10 (10 being excellent), how would you rate the condition of your mouth? \_\_\_\_\_
4. Do you have any nervousness or fear of having dentistry done.....YES NO  
If so, please explain \_\_\_\_\_
5. Do you have bleeding gums?.....YES NO  
If so, please explain \_\_\_\_\_
6. Do your gums feel tender or swollen?.....YES NO
7. Have you ever had gum treatment?.....YES NO
8. Do any of the following cause pain or sensitivity in your mouth?  
Cold \_\_\_\_\_ Heat \_\_\_\_\_ Pressure \_\_\_\_\_ Sweets \_\_\_\_\_
9. How often do you brush your teeth? \_\_\_\_\_
10. How often do you floss your teeth? \_\_\_\_\_
11. Are you aware of clenching or grinding your teeth during the day?.....YES NO
12. Have you been made aware of grinding or clenching your teeth at night?.....YES NO
13. Do you have chronic headaches, neck or shoulder pain?.....YES NO
14. Do you ever wake up with an awareness or soreness of your teeth or jaws as if you've had them clenched in your sleep?.....YES NO
15. Do you have any awareness of pain in the muscles of your neck or shoulders?.....YES NO
16. Do you ever have a tight or stiff neck?.....YES NO
17. Do you now, or have you ever had, pain in your jaw joint (TMJ) or the sides of your face (either in the muscles or in and about your ears)?.....YES NO
18. Do you have a clicking in your jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?.....YES NO
19. Which side do you normally chew on? Left \_\_\_\_\_ Right \_\_\_\_\_ Both \_\_\_\_\_

20. Do you understand the term "Traumatic Occlusion"?.....YES NO
21. Does your regular diet include any of the following:  
 Sweets \_\_\_\_\_ Soda Pop \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_
22. Do you smoke or use tobacco in any other form?.....YES NO  
 If so, in what form and how frequently \_\_\_\_\_
23. What is the reason for your visit today and how may we help you? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ADDITIONAL REMARKS OR QUESTIONS:

\_\_\_\_\_  
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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAYMENT:** We request payment for dental work at the time the service is performed unless previous arrangements have been made. Payment may be made by cash, check or credit card. To avoid misunderstanding regarding dental insurance, we would like our patients to know that all professional services rendered are charged directly to the patient and that all patients are personally responsible for payment of fees. Upon completion of your treatment, we will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. If you have any questions, please do not hesitate to ask. Our staff would be pleased to assist you in any way possible.

**AUTHORIZATION:**

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION AND WILL NOT HOLD MY DENTIST OR ANY OTHER MEMBER OF HI/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THE QUESTIONNAIRE.

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 SIGNATURE OF PATIENT OR GUARDIAN