It is important that I know about your dental and medical history. Many things have direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.

YOUR DENTAL HISTORY

Is this your first dental visit ____________

How long since you have been to a dentist ____________

What was done then ____________

Did you have full mouth X-Rays ____________

How often did you visit a dentist before then ____________

Any complications with extractions ____________

Have you ever had gum treatments____________ When ____________

Do you feel you have bad breath at times ____________

Are your teeth sensitive to:

Heat__________Cold__________Sweets__________Sour__________

Have you had your teeth straightened ____________ When ____________

Are you having any discomfort at this time ____________

Do you use dental floss ____________ How often ____________

Between-the-teeth stimulator ____________ Water jet ____________

Do you have bleeding gums ____________ When ____________

Please list previous dentist ____________

Do you grind or clench your teeth ____________ When ____________

Unpleasant taste in mouth ____________

Any pain in or around your ears ____________

Do you hear popping clicking or snapping noises when you chew ______

Are you aware of any swelling or lump in your mouth ____________

If you wear a denture, how long ____________

MEDICAL HISTORY

Physician's name ____________ Date of last physical exam ____________

Phone # ____________ Address ____________

Do you have or have you had any of the following. Please indicate with check mark (✔)

_____ Artificial joints/Pins	_____ Blood transfusions	_____ Hepatitis	_____ Mitral Valve Prolapse
_____ Any heart problems	_____ Allergies to anesthetics	_____ Herpes	_____ Sinus Problems
_____ High blood pressure	_____ Allergies to medicines or drugs*	_____ Malignancies	_____ Strokes
_____ Low blood pressure		_____ Measles	_____ Typhoid Fever
_____ Circulatory problems	_____ Anemia	_____ Mumps	_____ Tonsillitis
_____ Nervous problems	_____ Arthritis	_____ Psychiatric care	_____ Tuberculosis
_____ Radiation treatment	_____ Asthma	_____ Rheumatic Fever	_____ Ulcer
_____ Excessive bleeding	_____ Diabetes	_____ Scarlet Fever	_____ Venereal Disease
_____ AIDS (HIV)	_____ Kidney problems	_____ Heart Murmur	_____ Other

Are you pregnant __________ Blood Pressure S___/D___/___ Do you need to be pre-medicated __________

Have you ever been hospitalized __________ If so, for what ____________

Please list all medications you are presently taking ____________

____

____

____

*Please list medicines or drugs allergic to ____________

____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

____

____

____

Date ____________ Your Signature ____________