



Birth date \_\_\_\_\_

**Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.**

## DENTAL

1. Are you having any discomfort at this time..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment?..... Yes No  
If so explain?.....
3. Does dental treatment make you nervous? No..... Slightly..... Moderately..... Extremely.....
4. Date of last dental visit .....
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?..... Yes No  
If so when?.....
6. How often do you brush .....
- Brush is: Soft ☐ Medium ☐ Hard ☐
7. Do you have or have you ever had any of the following?

## MOUTH

- |   |     |    |
|---|-----|----|
| Bleeding, sore gums .....               | Yes | No |
| Unpleasant taste/bad breath .....       | Yes | No |
| Burning tongue/lips .....               | Yes | No |
| Frequent blisters, lip/mouth .....      | Yes | No |
| Swelling/lumps in mouth .....           | Yes | No |
| Ortho treatments (braces) .....         | Yes | No |
| Biting cheeks/lips .....                | Yes | No |
| Clicking/popping jaw .....              | Yes | No |
| Difficulty opening or closing jaw ..... | Yes | No |

## TEETH

- |                          |     |    |
|--------------------------|-----|----|
| Loose teeth.....         | Yes | No |
| Sensitive to hot.....    | Yes | No |
| Sensitive to cold.....   | Yes | No |
| Sensitive to sweets..... | Yes | No |
| Sensitive to biting..... | Yes | No |
| Food impaction.....      | Yes | No |
| Clenching/grinding.....  | Yes | No |
| If so, when _____        |     |    |
| Shifting in bite.....    | Yes | No |
| Change in bite.....      | Yes | No |

- |                              |                     |     |    |
|------------------------------|---------------------|-----|----|
| 8. Do you use the following? | Change in bite..... | Yes | No |
| Brush .....                  |                     | Yes | No |
| Dental floss .....           |                     | Yes | No |
| Fluoride rinse .....         |                     | Yes | No |
| Other .....                  |                     |     |    |

## MEDICAL

- |  |     |    |
|--|-----|----|
| 1. Has there been any change in your general health within the past year.....  | Yes | No |
| 2. My last physical examination was on.....  |     |    |
| 3. Are you now under the care of a physician .....   | Yes | No |
| If so, what is the condition being treated .....   |     |    |
| 4. The name and address of my physician is .....   |     |    |
| 5. Have you had any serious illness within the past five (5) years.....  | Yes | No |
| If so, what was the illness .....  |     |    |
| 6. Have you been hospitalized or had an operation within the past five (5) years .....   | Yes | No |
| If so, what was the problem .....  |     |    |
| 7. Do you have or have you had any of the following diseases or problems   |     |    |
| a. Rheumatic fever or rheumatic heart disease .....  | Yes | No |
| b. Congenital heart disease.....   | Yes | No |
| c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) ..... | Yes | No |
| 1) Do you have pain in chest upon exertion.....  | Yes | No |
| 2) Are you ever short of breath after mild exercise .....  | Yes | No |
| 3) Do your ankles swell.....   | Yes | No |
| 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep.....   | Yes | No |
| d. Artificial or replacement valves .....  | Yes | No |
| e. Pacemaker.....  | Yes | No |
| f. Allergy .....   | Yes | No |
| g. Sinus trouble.....  | Yes | No |
| h. Asthma or hay fever.....  | Yes | No |
| i. Hives or a skin rash.....   | Yes | No |
| j. Fainting spells or seizures .....   | Yes | No |
| k. Diabetes .....  | Yes | No |
| 1) Do you have to urinate (pass water) more than six times a day.....  | Yes | No |
| 2) Are you thirsty much of the time .....  | Yes | No |
| 3) Does your mouth frequently become dry .....   | Yes | No |



l. Hepatitis, jaundice or liver disease .....	Yes	No
m. Arthritis or inflammatory rheumatism .....	Yes	No
n. Artificial or replacement joints, prosthetic .....	Yes	No
o. Digestive system—Ulcers or stomach disorders (colitis) .....	Yes	No
p. Kidney trouble .....	Yes	No
q. Tuberculosis .....	Yes	No
r. Persistent cough or cough up blood .....	Yes	No
s. Immune System disorders (including AIDS, HIV, ARC) .....	Yes	No
t. Venereal disease .....	Yes	No
u. Other .....		
8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? .....	Yes	No
a. Do you bruise easily .....	Yes	No
b. Have you ever required a blood transfusion .....	Yes	No
If so, explain the circumstances & when .....		
9. Have you ever tested positive for the AIDS virus? .....	Yes	No
10. Do you have any blood disorder such as anemia? .....	Yes	No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? .....	Yes	No
12. Are you taking any of the following:		
a. Antibiotics or sulfa drugs .....	Yes	No
b. Anticoagulants (blood thinners) .....	Yes	No
c. Medicine for high blood pressure .....	Yes	No
d. Cortisone (steroids) .....	Yes	No
e. Tranquilizers .....	Yes	No
f. Antihistamines .....	Yes	No
g. Aspirin .....	Yes	No
h. Insulin, tolbutamide (Orinase) or similar drug for diabetes .....	Yes	No
i. Digitalis or drugs for heart trouble .....	Yes	No
j. Nitroglycerin .....	Yes	No
k. Other medications .....	Yes	No
l. If "Yes" to any of the above, state drug name, dosage and frequency .....		
13. Are you allergic or have you reacted adversely to:		
a. Local anesthetics .....	Yes	No
b. Penicillin or other antibiotics .....	Yes	No
c. Sulfa drugs .....	Yes	No
d. Barbiturates, sedatives, or sleeping pills .....	Yes	No
e. Aspirin .....	Yes	No
f. Iodine .....	Yes	No
g. Codeine or other narcotics .....	Yes	No
h. Other .....		
14. Do you use any tobacco products .....	Yes	No
If so, how much per day and what .....		
15. Do you use any alcohol products .....	Yes	No
If so, how much per day/week/month and what .....		
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) .....	Yes	No
If so, how much per day and what .....		
17. Do you have any disease, condition, or problem not listed above that you think I should know about? .....	Yes	No
If so, explain .....		
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation .....	Yes	No
19. Are you wearing contact lenses .....	Yes	No
20. Are you experiencing stress or pressure in your work or at home .....	Yes	No

#### WOMEN

20. Are you pregnant .....	Yes	No
21. Do you have PMS or problems associated with your menstrual period .....	Yes	No
22. Are you taking birth control or hormone therapy .....	Yes	No

Remarks:

*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.*

Signature of Patient

Date

Signature of Dentist

Date