

DENTAL/MEDICAL HISTORY

When was your last dental appointment? _____ Previous Dentist Name? _____

Are your teeth sensitive to:

	YES	NO		YES	NO
HEAT?	<input type="radio"/>	<input type="radio"/>	COLD?	<input type="radio"/>	<input type="radio"/>
SWEETS?	<input type="radio"/>	<input type="radio"/>	BITING?	<input type="radio"/>	<input type="radio"/>
Does food catch between your teeth?				<input type="radio"/>	<input type="radio"/>
Do your gums bleed?				<input type="radio"/>	<input type="radio"/>
Do you have an unpleasant taste or odor in your mouth?				<input type="radio"/>	<input type="radio"/>
Do you ever avoid any part of the mouth while brushing?				<input type="radio"/>	<input type="radio"/>
Have you had a reaction to local anesthetic?				<input type="radio"/>	<input type="radio"/>
Are you dissatisfied with your teeth and their appearance?				<input type="radio"/>	<input type="radio"/>
Are you deeply concerned about the finances required to return your mouth to excellent dental health?				<input type="radio"/>	<input type="radio"/>
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?				<input type="radio"/>	<input type="radio"/>
Do you smoke?				<input type="radio"/>	<input type="radio"/>
Have you ever had any teeth removed?				<input type="radio"/>	<input type="radio"/>
How long have these teeth been missing? _____				<input type="radio"/>	<input type="radio"/>
Does anyone in your family wear dentures?				<input type="radio"/>	<input type="radio"/>
Do you feel you will eventually wear dentures?				<input type="radio"/>	<input type="radio"/>
Have you ever had braces?				<input type="radio"/>	<input type="radio"/>

	YES	NO
Do you have/or have had any general health problems?	<input type="radio"/>	<input type="radio"/>

If so, please specify: _____

Have you ever had any surgeries or hospitalizations? YES NO

If so, please specify: _____

Are you currently under a physician's care? Name: _____ YES NO

REASON: _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING HERBAL MEDICATIONS: _____

To the best of your knowledge, are you or have you ever been afflicted with ANY **heart Ailment OR HEART MURMUR? JOINT REPLACEMENTS?** YES NO

If so, please specify: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Diabetes	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
Epilepsy	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Respiratory Disease	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>
HIV Positive	<input type="radio"/>	<input type="radio"/>	Prolonged Bleeding	<input type="radio"/>	<input type="radio"/>
Healing Problems?	<input type="radio"/>	<input type="radio"/>	Phen-Phen Use?	<input type="radio"/>	<input type="radio"/>
Are you pregnant?	<input type="radio"/>	<input type="radio"/>	Allergy to Drugs?	<input type="radio"/>	<input type="radio"/>

SPECIFY ALLERGY: _____

Why did you leave your last dentist? _____

What is your present dental concern? _____

PATIENT SIGNATURE: _____ DATE: _____