MEDICAL HISTORY

General health (please check): Excellent ☐ Good ☐ Fair ☐ Poor ☐

Name and address of physician ______________________________

____

Last complete physical? ______________________________

Are you taking any medication now? Yes ☐ No ☐ For what purpose? ______________________________

Do you take Aspirin ☐ Ibuprofen ☐ or other Blood Thinners ☐ ______________________________

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

____ Any heart problems	____ Allergies to anesthetics	____ Hepatitis	____ Sinus Problems
____ High blood pressure	____ Allergies to medicines or drugs	____ Herpes	____ Stroke
____ Low blood pressure		____ Malignancies	____ Typhoid Fever
____ Circulatory problems	____ Allergies to__________	____ Measles	____ Tonsillitis
____ Nervous problems	____ Anemia	____ Mumps	____ Tuberculosis
____ Radiation treatments	____ Arthritis	____ Psychiatric care	____ Ulcer
____ Excessive bleeding	____ Asthma	____ Rheumatic Fever	____ Venereal Disease
____ AIDS	____ Diabetes	____ Scarlet Fever	____ Other

Blood Pressure: S____/D____/____

Have you ever been treated (other than diagnostic) with x-ray? .... Yes ☐ No ☐

Are you allergic to: Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐ ____________

Are you subject to prolonged bleeding? .... Yes ☐ No ☐

Are you subject to fainting spells? .... Yes ☐ No ☐

(Women) Are you pregnant? .... Yes ☐ No ☐ How long?____________

Do you need Pre-medication for heartmurmur ☐ joint replacement ☐ valve replacement ☐ other ☐ ____________

DENTAL HISTORY

Date of last dental visit? ____________ Dentist's Name ______________________________ Phone ____________

Did you have x-rays taken? .... Yes ☐ No ☐

Have you had all your teeth x-rayed in the past 3 years? .... Yes ☐ No ☐

Do you wear full or partial dentures? .... Yes ☐ No ☐ (If Yes) How old are they? ____________

Does any member of your family, including your parents, wear dentures? .... Yes ☐ No ☐

Are you dissatisfied with the appearance of your teeth? .... Yes ☐ No ☐

Have you had orthodontic treatment? .... Yes ☐ No ☐

Do you clench or grind your teeth during the day or night? .... Yes ☐ No ☐

Have you ever had pain in your jaw joint or your face (In and about your ears)? .... Yes ☐ No ☐

Does your jaw joint click .... Yes ☐ No ☐ Do you have difficulty opening your mouth widely? .... Yes ☐ No ☐

Do you have an unpleasant odor, or taste, in your mouth? .... Yes ☐ No ☐

Do your gums bleed when brushing? .... Yes ☐ No ☐ Have you had gum disease or pyorrhea? .... Yes ☐ No ☐

Is your mouth or teeth sensitive to: .... Pressure Yes ☐ No ☐ Cold Yes ☐ No ☐ Hot Yes ☐ No ☐

Does food catch between your teeth? .... Yes ☐ No ☐

Please add anything you feel is important for the doctor to know ______________________________

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We may request / report credit information to T.R.W., a credit rating institution.

Patient's Signature ______________________________