

Date

Chart No.

Name: Birthdate: Marital Status:

Address: City: State: Zip: Telephone:

Previous Address:

Occupation: Soc. Sec. No.

Employed By: Driver's License #:

Business Address: Telephone:

Name-Spouse/Guardian Occupation-Spouse: Birthdate:

Employed By:: Soc. Sec. No.:

Do You Have Dental Insurance? Company:

Your Dentist: Time With Him:

Your Physician: Address:

Referred By: Reason For Referral:

MEDICAL HISTORY

Date of last Physical Exam:
Are you presently under a physician's care?
If yes, for what condition?
Have you ever been hospitalized?
If yes, for what condition?

- Do you have any of the following problems?
1. Hepatitis, jaundice or liver disease?
2. Heart...
a. Rheumatic fever...
b. Heart murmur...
c. Heart trouble or stroke...
d. High blood pressure...
e. Low blood pressure...
f. Chest pains...
g. Stroke...
3. Allergies
a. Drug allergies...
b. Asthma, hay fever, sinus problems or allergies.
4. Epilepsy or seizures...
5. Diabetes...
Family history?...
6. Arthritis or rheumatism...
7. Have you ever had a joint replaced?
8. Stomach or duodenal ulcers...
9. Kidney disease or infection...
10. Have you ever tested positive for HIV (Aids Virus)?
11. Venereal disease...
12. Medical X-Ray treatments...
13. Glaucoma...
14. Abnormal bleeding problems or blood disorders...

Table with 2 columns: YES, NO. Rows corresponding to medical history questions.

- a. Prolonged bleeding following tooth extraction...
b. Anemia...
c. Clotting problems...
d. Other blood problems...
15. Medications
a. Do you take any drugs or medicines?
b. Do you take any prescribed blood thinners?
c. Do you take any blood thinners such as Aspirin, Motrin, Advil, etc.?
d. Do you pre-medicate prior to your dental appointments...
16. Have you taken other medications within the past year?
17. Are you a nervous person?
18. Do you wear contact lenses?
19. Have you had any other serious illnesses...
20. Do you smoke?
Women:
21. Are you pregnant?
22. Do you take birth control medication?
23. Are you presently in menopause?
24. Are you post-menopause?

Table with 2 columns: YES, NO. Rows corresponding to medical history questions.

DENTAL HISTORY

- 1. Have you ever had treatments for gum or other periodontal disease...
2. Do your gums bleed?
3. Do you grind your teeth during the night?
4. Do you clench your teeth during the day?
5. Do you have sore or sensitive teeth?
6. Do you have pain in jaw joint area?
7. Do you have clicking of jaw joint?

Table with 2 columns: YES, NO. Rows corresponding to dental history questions.

- 8. Have you ever had dental implants?
9. Do you have pain elsewhere in your face or jaws?
10. Have you ever had your teeth straightened?
11. Circle devices used in your oral hygiene: floss, toothpicks, water irrigation, electric toothbrush, other.
12. Estimated date of last dental cleaning:

Table with 2 columns: YES, NO. Rows corresponding to dental history questions.

Present dental complaints: Signature

Summary