

(This information is necessary for our files and will be considered CONFIDENTIAL)

Name: _____ Social Security No. _____ Birth Date _____

I. CIRCLE APPROPRIATE ANSWER (Leave Blank if you do not understand question)

- 1. Yes No Is your general health good?
- 2. Yes No Has there been a change in your health within the last year?
- 3. Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
- 4. Yes No Are you being treated by a physician now? For What? _____
Date of last Medical Exam: _____ Date of last Dental Appt.: _____
- 5. Yes No Have you had problems with prior dental treatment?
- 6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

- 7. Yes No Chest pain (angina)?
- 8. Yes No Swollen ankles?
- 9. Yes No Shortness of breath?
- 10. Yes No Recent weight loss, fever, night sweats?
- 11. Yes No Persistent cough, coughing up blood?
- 12. Yes No Bleeding problems, bruising easily?
- 13. Yes No Sinus problems?
- 14. Yes No Difficulty swallowing?
- 15. Yes No Diarrhea, constipation, blood in stools?
- 16. Yes No Frequent vomiting, nausea?
- 17. Yes No Difficulty urinating, blood in urine?
- 18. Yes No Dizziness?
- 19. Yes No Ringing in the ears?
- 20. Yes No Headaches?
- 21. Yes No Fainting spells?
- 22. Yes No Blurred vision?
- 23. Yes No Seizures?
- 24. Yes No Excessive thirst?
- 25. Yes No Frequent urination?
- 26. Yes No Dry mouth?
- 27. Yes No Jaundice?
- 28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

- 29. Yes No Heart disease?
- 30. Yes No Heart attack, heart defects?
- 31. Yes No Heart murmurs?
- 32. Yes No Rheumatic fever?
- 33. Yes No Stroke, hardening of arteries?
- 34. Yes No High blood pressure?
- 35. Yes No TB, emphysema, other lung diseases?
- 36. Yes No Hepatitis, other liver disease?
- 37. Yes No Stomach problems, ulcers?
- 38. Yes No Allergies to: drugs, foods, medications?
- 39. Yes No Family history of diabetes, heart problems, tumors?
- 40. Yes No AIDS or ARC?
- 41. Yes No Tumors, cancer?
- 42. Yes No Arthritis, rheumatism?
- 43. Yes No Eye disease?
- 44. Yes No Skin diseases?
- 45. Yes No Anemia?
- 46. Yes No VD (syphilis or gonorrhea)?
- 47. Yes No Herpes?
- 48. Yes No Kidney, bladder disease?
- 49. Yes No Thyroid, adrenal disease?
- 50. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

- 51. Yes No Psychiatric care?
- 52. Yes No Radiation treatments?
- 53. Yes No Chemotherapy?
- 54. Yes No Prosthetic heart valve?
- 55. Yes No Artificial joint?
- 56. Yes No Hospitalization?
- 57. Yes No Blood transfusions?
- 58. Yes No Surgeries?
- 59. Yes No Pacemaker
- 60. Yes No Contact lenses?

V. ARE YOU TAKING:

- 61. Yes No Recreational drugs?
- 62. Yes No Drugs, medicines (Incl. Aspirin)?
- 63. Yes No Tobacco in any form?
- 64. Yes No Alcohol?

Please list _____

VI. Women Only

- 65. Yes No Are you or could you be pregnant or nursing?
- 66. Yes No Taking birth control pills?

VII. ALL PATIENTS

- 67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature _____ Date _____

RECALL REVIEW:

- 1. Patient's signature _____ Date _____
- 2. Patient's signature _____ Date _____
- 3. Patient's signature _____ Date _____
- 4. Patient's signature _____ Date _____
- 5. Patient's signature _____ Date _____
- 6. Patient's signature _____ Date _____
- 7. Patient's signature _____ Date _____
- 8. Patient's signature _____ Date _____
- 9. Patient's signature _____ Date _____
- 10. Patient's signature _____ Date _____