HEALTH INFORMATION

Name: _____ Date of birth: _____

DENTAL HISTORY Please circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations routinely? Date of last visit _____ Yes No
Do you think you have active decay? _____ Yes No
Do your gums bleed? (This may be a sign of gum disease) _____ Yes No
Do you brush on a routine basis? _____ Yes No
Do you floss on a routine basis? _____ Yes No
Do you clench or grind your teeth? _____ Yes No
Do you ever have discomfort in the jaw joint? _____ Yes No
Do you smoke or chew? _____ Yes No
Do you have frequent or recurring mouth sores? _____ Yes No

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ Who? _____ Yes No
Have you ever had any serious illness, significant operation or hospitalization? _____ Yes No
Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies? _____ Yes No
If so, please list: _____

Do you now have or have you ever had any of the following diseases or problems?
(Problems with an * may/likely require antibiotics prior to your dental visits.) Please call our office prior to answering if necessary.

Damaged heart valves (including Mitral Valve Prolapse), artificial valves or heart murmur? _____ Yes No
Rheumatic Heart Disease? _____ Yes No
Heart trouble, heart attack, angina, high/low blood pressure, stroke, stents, pacemaker or other heart condition? ____ Yes No
Joint replacement(s)? _____ Yes No
Any disease, drug or transplant operation that has depressed your immune system? _____ Yes No
Blood disorders such as anemia, abnormal bleeding, blood transfusion? _____ Yes No
Respiratory problems, emphysema, bronchitis, tuberculosis? _____ Yes No
Arthritis or painful, swollen joints including jaw joint (TMJ)? _____ Yes No

Please circle if you now have or have ever had any of the following diseases or problems.

Diabetes
Thyroid Problems
Persistent cough or cough that produces blood
Kidney trouble
Epilepsy or neurological disorder
Tumor, growths, or cancer
HIV Positive, AIDS
Allergies, sinus trouble, asthma, hay fever
Stomach ulcer or hyperacidity
Fainting spells or seizures
Persistent swollen neck glands
Sexually Transmitted Disease
Hepatitis, jaundice or liver disease

Are you allergic to or have you had a reaction to:

Local anesthetics? _____ Yes No
Antibiotics? _____ Yes No
Sulfa drugs? _____ Yes No
Sulfites? _____ Yes No
Codeine or other narcotics? _____ Yes No
Latex or rubber products? _____ Yes No
Other? _____ Yes No

Do you have any other condition or disease not checked above? Please explain _____ Yes No
Women: Are you pregnant or trying to become pregnant? _____ Yes No
Are you nursing? _____ Yes No
Are you taking birth control pills? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. Realizing this is my responsibility, any changes in my health status or my medicines, I shall inform the dentist and staff prior to the next appointment.

X_____ _____ X_____ _____
Patient signature (Parent or Guardian) Date Dentist signature BP/HR

DATE	EXCEPTIONS	PT INIT.	BP	STAFF
		PT INIT.	BP	STAFF