MEDICAL HISTORY (PLEASE CIRCLE YES OR NO)

1. Has there been a recent change in your health? ..... No Yes
   If yes, please explain: _____
2. When was your last physical examination? _____
3. Are you under the care of a physician? ..... No Yes
   If yes, condition: _____
4. Have you been hospitalized or had a serious illness within the last 5 years? ..... No Yes
   If yes, what was the problem: _____
5. Do you have or have you had any of the following? (Please check appropriate conditions) ..... No Yes

☐ Rheumatic Fever or Heart Problem	☐ Diabetes	☐ Psychiatric Conditions and Therapy
☐ Asthma or Hay Fever	☐ Hepatitis, Jaundice or Liver Disease including Hepatitis A,B,C & Delta	☐ Do You Consume Alcohol?
☐ Fainting Spells or Seizures	☐ Arthritis or Rheumatism	☐ Do you use Narcotic Drugs?
☐ Tuberculosis	☐ Heart Murmur	☐ Are You a smoker?
☐ Radiation Therapy	☐ Kidney Problems	☐ Family History of any of above medical conditions
☐ High/Low Blood Pressure	☐ Venereal Disease	
☐ Abnormal Bleeding or Blood Disorders	☐ Do you have AIDS, A.R.C. or are you HIV Positive?	
☐ Have you had any joints/organs/body parts in your body replaced with artificial joints		

6. Do you have difficulty breathing through your nose? ..... No Yes
7. **Are you currently taking any medication?** ..... No Yes
   If yes, list: _____
8. **Are you allergic to any drugs or medications such as Penicillin, Codeine or Aspirin?** ..... No Yes
   If yes, What: _____
9. Do you have any disease, condition or other problems listed above that you think I should know about? ..... No Yes
   If yes, describe: _____
10. Are you Aware of any lumps in your mouth? ..... No Yes

WOMEN ONLY

1. Are you pregnant? If so, how many Months? _____ No Yes
2. Are you taking birth control pills? ..... No Yes

DENTAL HISTORY

1. Are you aware of any dental problems at this time? ..... No Yes
2. When was you last dental visit? _____
   What was performed? _____
3. Are you seen in a dental office on a regular basis? ..... No Yes
4. Have you had a set of full mouth X-rays in the last 3 years? ..... No Yes
   If no, when was the last set? _____
5. Have you had a dental cleaning within the last year? ..... No Yes
   If not, when was your last cleaning? _____
6. Have you had any of the following treatment? Orthodontics, Endodontics (Root Canal), Periodontics (Gum Therapy) .. No Yes
   If yes, please specify: _____
7. Do you experience pain or clicking in your jaw, ear, or facial muscles upon opening your mouth? ..... No Yes
8. Have you ever had instructions in oral hygiene technique? ..... No Yes
9. How often do you brush your teeth? _____
10. Do your gums bleed? ..... No Yes
11. Are you aware of grinding or clenching your teeth? ..... No Yes
12. Do you suffer anxiety or gagging during dental procedures? ..... No Yes
13. How are your teeth important to you? _____
14. Do you want to avoid dentures? Why _____
15. Are you unhappy with the appearance of your teeth? ..... No Yes
    Why: _____
16. What changes would you make? _____

Patient's (or Guardian's) Signature _____ Date: _____

Reviewed by _____ Date: _____