MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: Please check Yes or No

Yes	No		Yes	No	
___	___	Heart Problems	___	___	Hepatitis or Liver Disease
___	___	High Blood Pressure	___	___	Complications of Healing
___	___	Rheumatic Fever	___	___	Serious Illnesses
___	___	Diabetes	___	___	Epilepsy
___	___	Major Operation	___	___	Asthma or Breathing Problems
___	___	Tuberculosis	___	___	Aids or HIV
___	___	Kidney Problems			

1. Have you been told that you need to be premedicated before dental care? ___Yes ___No
2. Have you had radiation therapy? ___Yes ___No
3. Do you use tobacco products? ___ Yes ___ No
4. Are you currently taking any drugs or medications? ___ Yes ___ No
   If so, please list:
   _____
   _____
   _____
5. For female patients only: Are you pregnant? ___Yes ___No If so, how far along: _____
6. Are there any additional medical problems we should know about: ___Yes ___No
   If so, please explain:
   _____
   _____
   _____

DENTAL HISTORY

1. Are you experiencing pain from your mouth at this time? ___Yes ___No
2. What prompted you to seek dental care at this time?
   _____
   _____
3. Do your gums bleed? ___Yes ___No
4. Have you noticed any loose or tipped teeth? ___Yes ___No
5. Do you clench or grind your teeth while sleeping or during the day? ___Yes ___No
6. Do you have popping, clicking or pain in your jaw joints? ___Yes ___No
7. Do you have headaches regularly? ___Yes ___No

8. Do you often lose or break fillings? ___Yes ___No
9. Are your teeth sensitive to hot, cold, or sweets? ___Yes ___No If so which: _____
10. Are you satisfied with the appearance of your teeth? ___Yes ___No
11. In general, do you feel that you have good oral health? ___Yes ___No
12. Have you been satisfied with past dental treatment? ___Yes ___No
13. Has the fear of discomfort kept you from regular dental visits? ___Yes ___No
14. Do you want to know the problems you have that may lead to the future breakdown of your oral health? ___Yes ___No
15. Do meats wedge between your teeth? ___Yes ___No
16. Have you noticed any mouth odors or bad taste? ___Yes ___No
17. Do you feel that you will lose more teeth and eventually have to wear full dentures? ___Yes ___No
18. Would you be tremendously disturbed if you had to lose your teeth and wear dentures? ___Yes ___No
19. Do you ever have difficulty chewing your food? ___Yes ___No
20. Do you like your smile? ___Yes ___No
21. Have you ever considered whitening, bonding or braces? ___Yes ___No