Name_____ Date_____

Address_____ Date of Birth_____

Social Security Number_____ Home Phone Number_____

Medical Physician _____ Office Phone Number_____

Approximate date of last physical examination_____

PATIENT MEDICAL HISTORY

						YES	NO
1.	Are you under any medical treatment now?						
2.	Have you had any major operations? If so, what?						
3.	Have you ever had a serious accident involving head injuries?						
4.	Have you had any adverse response to any drugs including penicillin?						
5.	Has a physician ever informed you that **you have / had**:						
6.	**Any blood disease?**	YES	NO	**A heart ailment?**			
7.	**Any kidney disease?**	YES	NO	**Diabetes?**			
8.	**Any liver disease?**	YES	NO	**Hepatitis?**			
9.	**Any Rheumatism or Arthritis?**	YES	NO	**High blood pressure?**			
10.	**Any stomach or intestinal disease?**	YES	NO	**Respiratory Disease?**			
11.	**Tumors or Growths?**	YES	NO	**Rheumatic fever?**			
12.	**Any venereal disease?**	YES	NO	**Yellow jaundice?**			
13.	**HIV infection?**	YES	NO	**AIDS?**			
14.	Do you have night sweats accompanied by weight loss or coughing?						
15.	Are you on a diet at this time?						
16.	Are you now taking any drugs or medications?						
17.	Are you allergic to any known materials resulting in hives, asthma, etc.?						
18.	Are you in general good health today?						
19.	Have any wounds healed slowly or presented other complications?						
20.	Are you pregnant?						
21.	Do you have a history of fainting?						
22.	Have you ever had X-RAY TREATMENT (other than diagnosis)?						

PATIENT DENTAL HISTORY

23.	Do you have pain in your ears?		
24.	Do you have any unhealed injuries or inflamed areas in or around your mouth?		
25.	Have you experienced any growth or sore spots in your mouth?		
26.	Does any part of your mouth hurt when clenched?		
27.	Have you ever had Novocaine anesthetic?		
28.	Any reactions or allergic symptoms to Novocaine?		
29.	Any difficult extractions in the past?		
30.	Prolonged bleeding following extractions in the past?		
31.	Trench mouth?		
32.	Do your gums bleed?		
33.	Have you ever had instructions on the correct method of brushing your teeth?		
34.	Have you ever had instructions on the care of your gums?		
35.	Do you chew on only one side of your mouth? If so, why?		
36.	Do you at the present time have any dental complaints?		
37.	Do you habitually clench your teeth during the night or day?		
38.	When was your last full mouth X-RAY taken? Where?		
39.	Is any part of your mouth sore to pressures or irritants (cold, sweets, etc.) If so, where?		

SIGNATURE_____ **(Circle One) Self Parent Guardian**