DENTAL HISTORY:

Have you been having any specific problem?____

Last dental visit?_____________ Purpose ________________________________Last complete exam_______

Has fear of discomfort kept you from regular visits?____

How would you describe your present dental health? GOOD FAIR POOR

Do you think you have active dental disease? ____________ Decay?___________ Gum Disease?___________

Describe you home care? Brush: _________ Floss: _________ Water Jet: _________ Mouthwash: __________

Do your gums ever bleed?______________________ Are your gums ever sore?_________________________

How do you feel about ever losing your teeth?____

MEDICAL HISTORY **(please circle yes or no)**

1. Have you been a patient in a hospital during the past 5 years? YES NO
2. Are you now or have you been under the care of a physician

   during the past 5 years? YES NO
3. Have you taken any kind of medicine or drugs during the past year? YES NO
4. Are you allergic to any drugs or medications? YES NO

   If so please provide:____
5. Have you ever had excessive bleeding requiring special treatment? YES NO
6. Have you ever had (circle ones that apply)

Heart Trouble	High Blood Pressure	Rheumatic Fever	Heart Murmur
Joint Replacement	Asthma	Cough	Tuberculosis
Diabetes	Hepatitis	Jaundice	Aids
Arthritis	Stroke	Epilepsy	Psychiatric Treatment

7. Have you ever had any other serious illness?____
8. Have you ever had any unusual effects from any previous

   dental treatment? YES NO
9. Do you use cocaine or any recreational drugs? YES NO
10. Do you prefer a local anesthetic (novocaine) for most dental

treatment? YES NO

11. (Women) Are you pregnant now? YES NO

12. (Women) Are you undergoing menopause now? YES NO

Physician's Name____Phone_________________________

Blood Pressure____________ Allergies_________________ Medical Alert______________________________

Medications:____

Date:_________________________ Signature: ____