DENTAL HISTORY:

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

Have you been having any specific problem? _____

Last dental visit? _____ Purpose _____ Last complete exam _____

Has fear of discomfort kept you from regular visits? _____

Do you think you have active dental disease? _____ Decay? _____ Gum Disease? _____

Describe your home care? Brush: _____ Floss: _____ Water Jet: _____ Mouthwash: _____

Do your gums ever bleed? _____ Are your gums ever sore? _____

Do you prefer a local anesthetic (novocaine) for most dental treatment? YES / NO

Have you ever had any unusual effects from any previous dental treatment? _____

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

   Physician's Name_____Phone_____
3. Have you taken any kind of medicine or drugs during the past year? YES NO
   Please List: _____
4. Allergic to any drugs or medications? YES NO
   Please List: _____
5. Have you ever had excessive bleeding requiring special treatment? YES NO
6. Have you ever had? (Please 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. Do you use cocaine or any recreational drugs? YES NO
9. (Women) Are you pregnant now? YES NO
10. (Women) Are you undergoing menopause now? YES NO

Date:_____ Signature of Patient or Guardian: _____