

GENERAL HEALTH INFORMATION CHART # _____

DATE: _____

PATIENT NAME: _____ LAST _____ FIRST _____ BIRTH DATE: _____ AGE: _____

DENTAL HISTORY

1. Reason for Visit / Main Concern? Check-Up Cleaning Toothache Other _____
2. Are there other conditions of which we should be aware? YES NO If yes, please specify: _____
3. When did you last visit a dentist? _____
4. What treatment was performed? _____
5. Was the treatment completed? _____
6. When were dental x-rays taken? _____
7. Did you have a cleaning? YES NO
8. Have you had gum (periodontal) treatment? YES NO
9. Have you ever had prolonged bleeding after an extraction? YES NO If yes, please specify: _____
10. Have you had any problems with past dental treatment? YES NO If yes, please specify: _____
11. Do you grind your teeth, clench your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES NO If yes, please specify: _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES NO If yes, please specify: _____
13. Do your gums bleed easily? YES NO
14. Do you feel you have bad breath? YES NO
15. Are your teeth sensitive to hot or cold? YES NO
16. Would you like your teeth whiter? YES NO
17. Are you happy with your smile? YES NO If no, please explain: _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES NO If yes, please specify: _____ Dr. Name: _____
Dr. Phone: () _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES NO If yes, please specify: _____
4. (Woman) Are you pregnant at this time? YES NO If yes, please specify how many months: _____
5. Are there any other health problems of which we should be advised? Please specify: _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"	Doctor Comments	Please check "YES" or "NO"	Doctor Comments
ARTIFICIAL Heart Valve	YES <input type="checkbox"/> NO <input type="checkbox"/>	HEPATITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>
AIDS/HIV+	YES <input type="checkbox"/> NO <input type="checkbox"/>	HIGH BL. PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/>
ANEMIA	YES <input type="checkbox"/> NO <input type="checkbox"/>	JAUNDICE	YES <input type="checkbox"/> NO <input type="checkbox"/>
ANGINA	YES <input type="checkbox"/> NO <input type="checkbox"/>	JOINT REPLACEMENT	YES <input type="checkbox"/> NO <input type="checkbox"/>
ARTHRITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	KIDNEY DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>
ASTHMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	LATEX ALLERGY	YES <input type="checkbox"/> NO <input type="checkbox"/>
BLEEDING PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	LIVER PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>
CANCER	YES <input type="checkbox"/> NO <input type="checkbox"/>	LOW BL. PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/>
CHEMO/RAD THERAPY	YES <input type="checkbox"/> NO <input type="checkbox"/>	LUNG DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>
COSMETIC SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/>	PACEMAKER	YES <input type="checkbox"/> NO <input type="checkbox"/>
DIABETES	YES <input type="checkbox"/> NO <input type="checkbox"/>	PHEN-FEN	YES <input type="checkbox"/> NO <input type="checkbox"/>
DIZZY SPELLS	YES <input type="checkbox"/> NO <input type="checkbox"/>	PSYCHIATRIC CARE	YES <input type="checkbox"/> NO <input type="checkbox"/>
DRUG ADDICTION	YES <input type="checkbox"/> NO <input type="checkbox"/>	RHEUMATIC FEVER	YES <input type="checkbox"/> NO <input type="checkbox"/>
EMPHYSEMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	SINUS TROUBLE	YES <input type="checkbox"/> NO <input type="checkbox"/>
EPILEPSY	YES <input type="checkbox"/> NO <input type="checkbox"/>	SMOKING TOBACCO	YES <input type="checkbox"/> NO <input type="checkbox"/>
FAINTING	YES <input type="checkbox"/> NO <input type="checkbox"/>	STROKE	YES <input type="checkbox"/> NO <input type="checkbox"/>
GLAUCOMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	THYROID PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>
HEART ATTACK	YES <input type="checkbox"/> NO <input type="checkbox"/>	TMD OR TMJ	YES <input type="checkbox"/> NO <input type="checkbox"/>
HEART SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/>	TUBERCULOSIS	YES <input type="checkbox"/> NO <input type="checkbox"/>
HEART MURMUR	YES <input type="checkbox"/> NO <input type="checkbox"/>	VENEREAL DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>
HEART PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>		

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature _____ Date _____
(Parent if Patient is a Minor) Doctor Signature _____

MEDICAL UPDATE:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____