Last Name ______________________ First Name ______________________ Date of Exam ______________

MEDICAL HEALTH HISTORY

General Health (please check):

☐ Excellent ☐ Good ☐ Fair ☐ Poor

If female: Are you pregnant? How long?

Who is your physician?

Physician's address

When did you have your last complete physical examination?

Are you being treated for anything now? Recent Surgery?

Do you or did you ever have:

	☐ High Colesterol	☐ AIDS or HIV +	☐ Tuberculosis
☐ Kidney Disease	☐ Liver Disease	☐ Asthma	☐ Diabetes
☐ Rheumatic Fever	☐ Anemia	☐ Epilepsy/Convulsions	☐ Heart Trouble
☐ Thyroid	☐ Hepatitis	☐ Venereal Disease	☐ Other ______

Is your blood pressure: ☐ high ☐ low ☐ normal

Blood pressure reading

Have you ever been treated with radiation?

Are you allergic to (Please check):

☐ Penicillin ☐ Codeine ☐ Other

☐ Novocaine ☐ Latex Are you taking Birth Control Pills?______

Are you allergic to any other drugs? (Please specify)

Are you taking any medications now? If so, what? ______

Are you subject to prolonged bleeding?

Are you "high strung"?

Has your diet ever been evaluated?

Do you have trouble sleeping?

Do you have problems with digestion?

Do you smoke or chew tobacco? ☐ yes ☐ no If yes, please specify number of:

cigarettes per day ____ pipefulls per day____ cigars per day____ chews per day____

Signature ______________________

DENTAL HEALTH HISTORY

Date of last dental exam ______________

1. What concerns you most about your dental health?
2. Do you have any pain in your teeth because of heat, cold or sweets? If so, where?
3. Do you have any pain in any part of the mouth or in any tooth while biting or chewing? If so, where?
4. Does food catch between your teeth? If so, where?
5. Do your gums bleed, either in chewing or brushing or at any other time? If so, when?
6. Do you clench your teeth during the day? Have you been made aware of clenching your teeth during the night?
7. Do you brush your teeth vigorously or lightly?

   How often do you brush your teeth?

   Do you avoid any part of the mouth while brushing?
8. Do your gums feel irritated, tender or swolen?
9. Are you completely happy with the appearance of your teeth?
10. Do you have all your teeth (other than wisdom teeth)?
11. If not, did you have missing teeth replaced?
12. Were you told why your missing teeth should be replaced?
13. Do you lose fillings or break silver fillings?
14. Do you feel that dentures are inevitable?
15. How often do you have calculus (tartar) removed? Every months
16. Do you want to keep your own teeth as long as possible?