Name _____

Address _____

City _____ Zip Code _____

Date _____
Date of Birth _____
Home Phone _____
Business Phone _____
Cell Phone _____
Soc. Sec. No. _____

PATIENT HEALTH HISTORY

Physician _____ Office Phone _____
Approximate Date of last physical examination _____

		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: A Heart Ailment/Murmur?	___	___
	Yes No Diabetes?	___	___
6.	High Blood Pressure? _____ _____ Respiratory Disease?	___	___
7.	Rheumatic Fever? _____ _____ Rheumatism or Arthritis?	___	___
8.	Tumors or Growths? _____ _____ Any Blood Disease?	___	___
9.	Any Liver Disease? _____ _____ Any Kidney Disease?	___	___
10.	Aids? _____ _____ Yellow Jaundice or Hepatitis?	___	___
11.	Any Venereal Disease? _____ _____ Any Stomach or Intestinal Disease?	___	___
12.	Do you have night sweats accompanied by weight loss or cough?	___	___
13.	Are you on a diet at this time?	___	___
14.	Are you now taking drugs or medication?	___	___
15.	Are you allergic to any known materials resulting in hives, asthma, eczema, etc?	___	___
16.	Are you in general good health at this time?	___	___
17.	Have any wounds healed slowly or presented other complications?	___	___
18.	Are you pregnant?	___	___
19.	Do you have a history of fainting?	___	___
20.	Have you ever had any radiation treatment?	___	___

PATIENT DENTAL HISTORY

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

Signature _____

By initialing this, I acknowledge that I have reviewed this history and have made the necessary changes and dated for verification.