DENTAL CLINIC

(please print and complete both sides of this form)

NAME		*	
MEDICAL HISTORY	•	DO NOT WRITE IN THIS SPACE	
CHIEF COMPLAINT_			
1. [] Yes [] No	Are you having pain or discomfort at this time?		
2. [] Yes [] No Do you feel very		y nervous about having dental treatment?	*
3. [] Yes [] No	Have you ever	had a bad experience in a dental office?	
4. [] Yes [] No	Have you been two years?	a patient in a hospital during the past	
5. []Yes []No	Have you been during the past	under the care of a medical doctor two years?	
6. [] Yes [] No	Have you taker two years?	any medicine or drugs during the past	
7. []Yes []No	feet or eyes) or	(i.e., itching, rash, swelling of hands, made sick by penicillin, aspirin, drugs or medications?	
8. [] Yes [] No	Have you ever had any excessive bleeding requiring special treatment?		
9. Check [] any o [] Heart Failure [] Heart Diseas [] Angina Pecto [] High Blood P [] Heart Murmu [] Rheumatic Fe [] Congenital H [] Scarlet Fever [] Artificial Heart [] Heart Pacem [] Heart Surger [] Artificial Joint [] Anemia [] Stroke [] Kidney Troub [] Ulcers [] Headaches [] Mentally Han [] Brain Injury [] Wheelchair D [] Emphysema [] Cough [] Tobacco Use [] Tuberculosis [] Asthma [] Hay Fever [] Sinus Trouble [] Allergies or H	e or Attack oris ressure r ever eart Defects r t Valve aker y ole dicapped Dependent (TB)	nich you have had or have at present: [] Diabetes [] Thyroid Disease [] Cancer, Leukemia [] X-ray or Cobalt Treatment [] Chemotherapy [] Arthritis [] Rheumatism [] Cortisone / Steroid Medicine [] Glaucoma [] Pain in Jaw Joints [] HIV [] Hepatitis A (infectious) [] Hepatitis B (serum) [] Liver Disease [] Yellow Jaundice [] Blood Transfusion [] Drug Addiction [] Alcohol Abuse [] Hemophilia [] Venereal Disease (Syphilis, Gonorrhea) [] Cold Sores [] Epilepsy or Seizures [] Fainting or Dizzy Spells [] Nervousness [] Psychiatric Treatment [] Sickle Cell Trait / Disease [] Bruise Easily	

10. [] Yes [] No	When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are tired?			
11. [] Yes [] No	Do your ankles swell during the day?			
12. [] Yes [] No	Have you lost or gained more than 10 pounds in the past year?			
13. [] Yes [] No	Do you ever wake up from sleep short of breath /or sweating heavily?			
14. [] Yes [] No	Are you on a special diet? Doctor's order or self-imposed?			
15. [] Yes [] No	Has your medical doctor ever said you have a cancer or tumor?			
16. [] Yes [] No	Do you have any disease(s), conditions(s) or problem(s) not listed?			
17. [] Yes [] No [] Yes [] No [] Yes [] No	Women: a) Are you pregnant now? b) Are you practising birth control? c) Do you anticipate becoming pregnant?			
18. Please list all your current medications				
DENTAL HISTORY				
1. []Yes []No	Are you having dental pain?			
2. []Yes []No	Do you think you have gum problems?			
3. []Yes []No	Do you notice popping, clicking or soreness of the jaw or just in front of your ears?			
4. [] Yes [] No	Are you involved in any contact sports? (i.e. hockey, football, boxing, basketball, etc.)			
5. []Yes []No	Do you brush daily?			
6. []Yes []No	Do you floss daily?			
7. []Yes []No	Have you ever had dental freezing (local anaesthetic) problems?			
8. a. When was your last dental visit? c. When were your last dental x-rays taken?				
b. What was done? d. Who was your last dentist?				
9. a. Do you wear complete or partial dentures?				
b. How many years have you worn dentures?				
c. How old are your present dentures?				
To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health,				
or if my medicines change, I will inform the dental staff at the next appointment without fail.				
* 1				
DATE	PATIENT OF GUARDIAN SIGNATURE DENTIST SIGNATURE			