HEALTH INFORMATION
All information is confidential

☐Yes ☐No 1. Have you come to this office for the relief of pain?
If yes, where is the pain?_____

☐Yes ☐No 2. Have you been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?

☐Yes ☐No 3. Has a dentist or hygienist shown you how to clean your teeth?

☐Yes ☐No 4. Do you have sores, swellings or blisters on your gums, cheeks or lips?

☐Yes ☐No If yes, have they been present longer than 3-4 weeks?

☐Yes ☐No 5. Have you had orthodontic treatment to straighten your teeth?

☐Yes ☐No 6. Do you have any dental implants?

☐Yes ☐No 7. Do you have clicking or popping jaw?

☐Yes ☐No 8. Do you have bleeding or infected gums?

☐Yes ☐No 9. Have you ever had an unusual reaction to dental anesthesia (gas or "shots")?

☐Yes ☐No 10. Are you now being treated or have you been treated within the last year by a physician?

☐Yes ☐No 11. Following injuries or dental treatment, have you had bleeding problems?

☐Yes ☐No 12. Is there a history of diabetes in your family?

☐Yes ☐No 13. Are you thirsty most of the time?

☐Yes ☐No 14. Have you recently lost weight unintentionally (with good appetite)?

☐Yes ☐No 15. Have you ever used intravenous drugs?

☐Yes ☐No 16. Have you had eye trouble recently?

☐Yes ☐No 17. Do injuries or cuts take longer to heal now than they did previously?

☐Yes ☐No 18. Does your mouth feel dry or do you have a burning sensation of lips of tongue?

☐Yes ☐No 19. Have you taken or been given injections of steroids such as Cortisone?

☐Yes ☐No 20. Do you smoke or use tobacco regularly?

☐Yes ☐No 21. Have you ever taken Phen-fen?

22. How would you describe your general health?
☐poor ☐fair ☐good

Date of last medical examination?_____

Have you become sick from, shown an allergy to, or been told *not* to take:

☐Yes ☐No Latex
☐Yes ☐No Antibiotics (penicillin, etc.)
☐Yes ☐No Codeine
☐Yes ☐No Novocain or other dental anesthetics
☐Yes ☐No Other drugs or medicines

_____

Are you now:

☐Yes ☐No Pregnant
☐Yes ☐No On a prescribed diet
☐Yes ☐No Using thyroid
☐Yes ☐No Using hormones(including birth control pills)
☐Yes ☐No Using anticoagulants
☐Yes ☐No Using Dilantin

Are you now taking or using medicines for:

☐Yes ☐No Diabetes (pills or shots)
☐Yes ☐No Nerves (tranquilizers)
☐Yes ☐No Sleeping
☐Yes ☐No Heart or blood pressure (digitals, Nitroglycerine, Resperine)
☐Yes ☐No Blood (liver or iron pills)
☐Yes ☐No Stomach trouble (ulcer or other)
☐Yes ☐No Headaches
☐Yes ☐No Arthritis or rheumatism
☐Yes ☐No Allergy

List all prescription and non-prescription drugs you are taking:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____

Have you ever had any of the following?

☐Yes ☐No Shortness of breath without exercise or when lying down
☐Yes ☐No Pain, pressure or tight feeling in chest
☐Yes ☐No Heart attack, stroke
☐Yes ☐No Rheumatic fever, heart murmur, valve prolapsed
☐Yes ☐No High blood pressure
☐Yes ☐No Frequent headaches (2-3 a week)
☐Yes ☐No A blood transfusion
☐Yes ☐No Nervous breakdown, psychotherapy
☐Yes ☐No Lung trouble (TB, asthma, emphysema)
☐Yes ☐No Hepatitis, liver disease, jaundice
☐Yes ☐No Arthritis or sore joints
☐Yes ☐No Bone or joint implants
If yes, where?_____ When?_____
☐Yes ☐No Diabetes
☐Yes ☐No Excessive bleeding
☐Yes ☐No Blood trouble, anemia, leukemia, tumor, cancer
☐Yes ☐No VD (syphilis, gonorrhea)
☐Yes ☐No Radiation, radium or cobalt treatments
☐Yes ☐No AIDS, HIV +
☐Yes ☐No Kidney disease
☐Yes ☐No Heart Disease

Patient Signature_____ Date_____Dr.Init._____

(parent or guardian) Date_____

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