Date: _____

Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Business Address: _____ Business Phone: _____

Soc. Sec. No.: _____

Patient Name: _____

PATIENT MEDICAL HISTORY

Physician: _____ Office Phone: _____ Home 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 had: A Heart Ailment?	❑	❑
6.	High Blood Pressure?	❑	❑
7.	Respiratory Disease?	❑	❑
8.	Diabetes?	❑	❑
9.	Rheumatic Fever?	❑	❑
10.	Rheumatism or Arthritis?	❑	❑
11.	Tumors or Growths?	❑	❑
12.	Any Blood Disease?	❑	❑
13.	Any Liver Disease?	❑	❑
14.	Any Kidney Disease?	❑	❑
15.	Any Stomach or Intestinal Disease?	❑	❑
16.	Any Venereal Disease?	❑	❑
17.	AIDS?	❑	❑
18.	Yellow Jaundice or Hepatitis?	❑	❑
19.	Do you have night sweats accompanied by weight loss or cough?	❑	❑
20.	Are you on a diet at this time?	❑	❑
21.	Are you now taking drugs or medications?	❑	❑
22.	Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?	❑	❑
23.	Are you in general good health at this time?	❑	❑
24.	Have any wounds healed slowly or presented other complications?	❑	❑
25.	Are you pregnant?	❑	❑
26.	Do you have a history of fainting?	❑	❑
27.	Have you ever had any X-RAY TREATMENTS (other than diagnostic)?	❑	❑

PATIENT DENTAL HISTORY

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

Signature: _____