Patient Name: ____________________ Date: ________

Dental Health Information

Name of Previous Dentist: ______________________________ Telephone #: ________________

Date of last dental exam: ____________ Cleaning: ____________ Full Mouth X-ray: ________

General Health Information

Name of Physician: ________________________________ Telephone #: __________________

Date of last medical exam: ____________________________ Is your general heath good? ________

Are you under a physicians care? If so, describe. ____

Have you ever had a serious illness, operation or hospitalization? If so, describe. ____________

____

Please circle **YES** or **NO** for the following questions. **(Leave blank if you do not understand the question.)**

Have you ever experienced:

Yes No Chest Pain (Angina)

Yes No Shortness of breath

Yes No Sinus problems

Yes No Dizziness

Yes No Blurred Vision

Yes No Seizures

Yes No Recent weight loss

Yes No Night sweats or fever

Yes No Bleeding problems

Yes No Bruising easily

Yes No Blood in stool or urine

Yes No Frequent vomiting/

Yes No Excessive thirst

Yes No Joint pain, stiffness

Are you taking:

Yes No Recreational Drugs

Yes No Tobacco in any form

Yes No Alcohol

Yes No Diet pills

Yes No Dietary supplements

FOR WOMEN ONLY

Yes No Are you, or could you be Pregnant?

Yes No Taking Birth Control Pills

*Antibiotics (and some other medications) may interfere with the effectiveness of your oral contraceptives. Please consult your Physician for further guidance.

Do you have or have you had:

Yes No Heart attack or defects

Yes No Heart murmurs

Yes No Rheumatic fever

Yes No Stroke

Yes No High Blood Pressure

Yes No Tuberculosis

Yes No Hepatitis, liver disease

Yes No Kidney, bladder disease

Yes No Pacemaker

Yes No Food Allergies

Yes No Latex or Drug Allergies

Yes No HIV or ARC

Yes No Tumors, Cancer

Yes No Arthritis, Rheumatism

Yes No Anemia

Yes No Syphilis or Gonorrhea

Yes No Herpes

Yes No Artificial Joint

Yes No Diabetes

Yes No Chemotherapy

Yes No Radiation

Yes No Contact Lenses

Yes No Blood transfusions

Yes No Psychiatric care

Do you have or had any other diseases not listed on this form? If so, Please list: ____________________

Please list all medications you are taking: ____

Please list all medications our are allergic to: ____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient and/or guardian signature: ________________________________ Date: ____________

Reviewed by: DDS Signature: ________________________________ Date: ____________