

Sex: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Telephone \_\_\_\_\_  
 Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Soc. Sec. No. \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Approximate date of last physical examination \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you under any medical treatment now?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had any major operations? If so what?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious accident involving head injuries?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any adverse response to any drugs including penicillin?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has a physician ever informed you that you had:                                    |                          |                          |
| 6.     A Heart Ailment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.     High Blood Pressure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.     Respiratory Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.     Diabetes?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10.    Rheumatic Fever?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.    Rheumatism or Arthritis?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12.    Tumors or Growths?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13.    Any Blood Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.    Any Liver Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15.    Any Kidney Disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16.    Any Stomach or Intestinal Disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17.    Any Venereal Disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18.    AIDS?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19.    Yellow Jaundice or Hepatitis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have night sweats accompanied by weight loss or cough?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Are you on a diet at this time?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Are you now taking drugs or medications?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are you allergic to any known materials resulting in hives, asthma, eczema, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Are you in general good health at this time?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have any wounds healed slowly or presented other complications?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are you pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you have a history of fainting?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever had any X-RAY TREATMENTS (other than diagnostic)?                   | <input type="checkbox"/> | <input type="checkbox"/> |

**PATIENT DENTAL HISTORY**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 28. Do you have pain in or near your ears?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any unhealed injuries or inflamed areas in or around your mouth?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you experienced any growth or sore spots in your mouth?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Does any part of your mouth hurt when clenched?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you ever had Novocaine anesthetic?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33.     Any reactions or allergic symptoms to Novocaine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 34.     Any difficult extractions in the past?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 35.     Prolonged bleeding following extractions in the past?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 36.     Trench Mouth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Do your gums bleed?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Have you ever had instruction on the correct method of brushing your teeth?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you ever had instructions on the care of your gums?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you chew on only one side of your mouth? If so why?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you at the present time have any dental complaints?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Do you habitually clench your teeth during the night or day?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.)?<br>If so locate _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Signature \_\_\_\_\_