Date _____

Name _____

Address _____

Business Address _____

Date of Birth _____
Telephone # _____
Business # _____
Soc. Sec. # _____

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 _____