

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?..... YES NO
If yes, for what reason?_____
2. Are you having dental problems at this time? YES NO
3. Do your gums bleed at any time?..... YES NO
4. Do you feel very nervous about having dental treatment?..... YES NO
5. Are you allergic to (i.e., itching, rash, swelling or hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? YES NO
If yes, please list. _____
6. Have you ever had excessive bleeding requiring special treatment? YES NO
7. Check any of the following which you have had or have at present:

<input type="checkbox"/> Heart disease or Attack	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Cortisone Medication or Injections
<input type="checkbox"/> Heart pacemaker	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcers (Stomach)
<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Heart murmur/mitral Valve	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> High blood Pressure	<input type="checkbox"/> Hepatitis B (Serum)	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Cancer or tumor	<input type="checkbox"/> HIV Positive(AIDS)	<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Chemotherapy (Cancer, Leukemia)	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cold Sores or Fever Blisters
- Do you have any disease, condition or problem not listed? If so, please list YES NO

8. List all medications you are taking at this time._____

9. Are you a smoker?..... YES NO
10. Do you use or have you ever used recreational drugs?..... YES NO
11. Do you ever wake up from sleep short of breath? Do you snore?..... YES NO
12. Do you clench or grind your teeth? YES NO
13. Do you have pain in your jaw joints or ringing in your ears?..... YES NO
14. Women: Are you pregnant YES NO If yes, what month are you due?_____
- How do you feel about getting and maintaining a healthy mouth?_____
- How do you feel about the appearance of your teeth?_____
- If you could change anything about your smile, what would you change? _____

Signature:_____ Date:_____