

Dental History: General

Are you having any discomfort at this time ? _____ How long since you have seen a dentist ? _____

Are your teeth sensitive to : Heat Cold Sweets Sour Other _____

Have you ever had gum treatments? _____ When? _____ By whom? _____

Do you currently have bleeding gums? _____ Does food wedge between your teeth? _____ Where? _____

Do you clench or grind your teeth? _____ When? _____

Have you had your teeth straightened? _____ When? _____ By Whom? _____

Do you feel you have bad breath at times? _____ When? _____ Unpleasant taste? _____

Any pain in or around your ears? _____ Do you hear popping, clicking or snapping when you chew? _____

Are there any lumps of swelling in your mouth? _____ Do you have any fear of dentistry ? _____

Dental History: Esthetic

Are your teeth: Chipped Protruding Hidden Discolored Crooked Large Spaces

Do you like the shape of your teeth? _____ Are there any fillings, caps you don't like looking at? _____

Do You Like Your Smile? _____ If not, why? _____

Medical History:

Physician's Name: _____ Telephone #: _____

Date of Last Physical Exam: _____ For what? _____

Blood Pressure: / Are You Taking Any Medications: (Y) (N) What? _____

Do you have any of the following :(*Please indicate with a check mark*)

- | | | |
|--|--|---|
| Any Heart Disease----- <input type="checkbox"/> | Allergies to medicines or drugs-- <input type="checkbox"/> | Psychiatric Care----- <input type="checkbox"/> |
| Heart Murmur----- <input type="checkbox"/> | Any other Allergies ----- <input type="checkbox"/> | Rheumatic Fever----- <input type="checkbox"/> |
| Mitral Valve Prolapse-- <input type="checkbox"/> | _____ | Scarlet Fever----- <input type="checkbox"/> |
| High Blood Pressure--- <input type="checkbox"/> | Asthma----- <input type="checkbox"/> | Typhoid Fever----- <input type="checkbox"/> |
| Low Blood Pressure--- <input type="checkbox"/> | Diabetes----- <input type="checkbox"/> | Tonsillitis----- <input type="checkbox"/> |
| Circulatory Problems-- <input type="checkbox"/> | Hepatitis----- <input type="checkbox"/> | Tuberculosis----- <input type="checkbox"/> |
| Nervous Problems----- <input type="checkbox"/> | Herpes----- <input type="checkbox"/> | Ulcer----- <input type="checkbox"/> |
| Radiation Treatments-- <input type="checkbox"/> | AIDS----- <input type="checkbox"/> | Venereal Disease---- <input type="checkbox"/> |
| Excessive Bleeding---- <input type="checkbox"/> | Malignancies (Cancer) ----- <input type="checkbox"/> | Are You Pregnant?-- <input type="checkbox"/> |
| Blood Transfusions--- <input type="checkbox"/> | Measles----- <input type="checkbox"/> | Emphysema----- <input type="checkbox"/> |
| Anemia----- <input type="checkbox"/> | Mumps----- <input type="checkbox"/> | Hay Fever----- <input type="checkbox"/> |
| Stroke----- <input type="checkbox"/> | Artificial Heart Valve----- <input type="checkbox"/> | Thyroid Disease----- <input type="checkbox"/> |
| Heart Pacemaker----- <input type="checkbox"/> | Artificial Joint----- <input type="checkbox"/> | Kidney Trouble----- <input type="checkbox"/> |
| Sinus Problems----- <input type="checkbox"/> | Chemotherapy----- <input type="checkbox"/> | Arthritis----- <input type="checkbox"/> |
| Rheumatism----- <input type="checkbox"/> | Glaucoma----- <input type="checkbox"/> | Cortisone Medicine-- <input type="checkbox"/> |
| Liver Disease----- <input type="checkbox"/> | Drug Addiction----- <input type="checkbox"/> | Hemophilia----- <input type="checkbox"/> |
| Epilepsy----- <input type="checkbox"/> | Fainting or Dizzy Spells----- <input type="checkbox"/> | Sickle Cell Disease--- <input type="checkbox"/> |
| Do you SMOKE? ---- <input type="checkbox"/> | | |

Do Your Feel That There Is Anything That You Would Like To Add? _____