

# MEDICAL AND DENTAL HISTORY

Name \_\_\_\_\_

HAVE YOU EVER HAD:	YES	NO
Hepatitis or Liver Disease		
Epilepsy/Seizures		
Rheumatic Fever		
Kidney Disease		
Diabetes		
Tuberculosis		
Heart Trouble		
Damage Heart Valves		
Artificial Heart Valves		
Congenital Heart Lesions		
Coronary Insufficiency		
Coronary occlusion		
Arteriosclerosis		
Stroke		
Cardiac Pacemaker		
Heart Murmur		
High/Low Blood Pressure		
Shortness of Breath		
Chest Pains		
Allergies		
Medical Treatment by X-Ray		
Venereal Disease		
Surgery		
Glaucoma		
Prostate Trouble		
Contact Lenses		
Drug Reaction		
Psychiatric Treatment		
Burning Tongue		
Ulcer		
Sinus Problems		
Asthma		
Treatment for a tumor/growth		
Prosthetic Replacement (Hip, knee, etc.)		
A.I.D.S. or H.I.V. Positive		

An Unfavorable Reaction to a Drug Such As:

Aspirin		
Barbiturates		
Anesthetics		
Penicillin		
Sulfa Drugs		
Other		

HAS A member of your family had Diabetes? Who? _____	YES	NO
At what age? _____		
IF FEMALE, ARE YOU NOW: Pregnant		
Taking anti-pregnancy drug		
Presently in the Menopause		
Past menopause		

ARE YOU:

Presently under the care of a physician		
Taking any medication now		
Or within the past year		
Such as:		
Anticoagulants		
Cortisone		
Tranquilizers		
Nitroglycerin		
Penicillin		
Aspirin		
Digitalis, heart medicine		
Medication for High Blood pressure		
Other		

Allergic to dental anesthetic		
Aware of recent weight change		
Subject to frequent urination		
Often thirsty		
Subject to frequent headaches		
Easily exhausted or fatigued		
Slow in healing		
In good health now		
Other		
Aware of grinding or clenching your teeth day or night		
Satisfied with the appearance of your teeth		

HAVE YOU:

Ever been told you had gum Trouble		
Ever had trench mouth		
Ever been treated for Periodontal Disease (Pyorrhea)		
Ever had Orthodontic Treatment		
Had shifting of any teeth		

DO YOU:	YES	NO
Ever have sore or popping joints		
Ever have sore teeth		
Ever notice your ankles swell		
Have prolonged bleeding after injury or tooth extraction		
Have a persistent cough or cough up blood		
Get short of breath when you lie down or require extra pillows when you sleep		
Have any blood disorder		
Smoke		
Use drugs		
Use alcohol		
Have habits such as:		
Pencil chewing		
Fingernail biting		
Pipe smoking		
Have unpleasant tastes in your mouth		
Have bleeding gums		
Have bad breath		
Have tooth sensitivity to heat		
to cold		
to sweets		
Use dental floss		
Have any fear of dental treatment		
Want to keep your teeth, Yes, no matter how much trouble		
Yes, if it's not too much trouble		
Don't know		
Don't care		
Any serious illness not listed		