



23. In the past 12 months, have you had a: Heart Attack? Y  N  Stroke? Y  N  Tia? Y  N

24. **WOMEN ONLY**

Are you pregnant or suspect you may be? Y  N  If yes, expected due date? \_\_\_\_\_

Are you breast-feeding? Y  N  Are you taking Birth Control Pills? Y  N

25. Please indicate which of the following you presently have or have ever had:

- |                                |   |   |   |   |   |
|--------------------------------|---|---|---|---|---|
| ADHD                           | Y <input type="checkbox"/> N <input type="checkbox"/> | Fibromyalgia                                    | Y <input type="checkbox"/> N <input type="checkbox"/> | Malignant Hypothermia                                 | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Heart Issue(s)                 | Y <input type="checkbox"/> N <input type="checkbox"/> | Glaucoma  | Y <input type="checkbox"/> N <input type="checkbox"/> | Migraines   | Y <input type="checkbox"/> N <input type="checkbox"/> |
| AIDS/HIV                       | Y <input type="checkbox"/> N <input type="checkbox"/> | Heart Issue(s)                                  | Y <input type="checkbox"/> N <input type="checkbox"/> | MS (Multiple Sclerosis)                               | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Anemia                         | Y <input type="checkbox"/> N <input type="checkbox"/> | <input type="checkbox"/> Heart Murmur           | Organ Transplant                                      | Y <input type="checkbox"/> N <input type="checkbox"/> |   |
| Arthritis                      | Y <input type="checkbox"/> N <input type="checkbox"/> | <input type="checkbox"/> Heart Rhythm Disorder  | Shingles  | Y <input type="checkbox"/> N <input type="checkbox"/> |   |
| Artificial Joint               | Y <input type="checkbox"/> N <input type="checkbox"/> | <input type="checkbox"/> Heart Surgery          | Sickle Cell Disease                                   | Y <input type="checkbox"/> N <input type="checkbox"/> |   |
| <input type="checkbox"/> Hip   |   | <input type="checkbox"/> Artificial Heart Valve | Speech Disorder                                       | Y <input type="checkbox"/> N <input type="checkbox"/> |   |
| <input type="checkbox"/> Knee  |   | <input type="checkbox"/> Angina                 | Stroke / TIA  | Y <input type="checkbox"/> N <input type="checkbox"/> |   |
| <input type="checkbox"/> Other |   | <input type="checkbox"/> Mitral Valve Prolapse  | Thyroid Disease                                       | Y <input type="checkbox"/> N <input type="checkbox"/> |   |
| Celiac Disease                 | Y <input type="checkbox"/> N <input type="checkbox"/> | <input type="checkbox"/> Other _____            | Tinnitus  | Y <input type="checkbox"/> N <input type="checkbox"/> |   |
| Cerebral Palsy                 | Y <input type="checkbox"/> N <input type="checkbox"/> | Hepatitis A B C                                 | Y <input type="checkbox"/> N <input type="checkbox"/> | Tuberculosis  | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Circulation Problems           | Y <input type="checkbox"/> N <input type="checkbox"/> | Herpes / Cold Sores                             | Y <input type="checkbox"/> N <input type="checkbox"/> | Ulcers (H. Pylori)                                    | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Crohn's/Colitis/IBS            | Y <input type="checkbox"/> N <input type="checkbox"/> | High/Low Blood Pressure                         | Y <input type="checkbox"/> N <input type="checkbox"/> | Venereal Disease                                      | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Cortisone/Steroids             | Y <input type="checkbox"/> N <input type="checkbox"/> | Kidney Disease                                  | Y <input type="checkbox"/> N <input type="checkbox"/> | Vertigo / Dizzy Spells                                | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Diabetes                       | Y <input type="checkbox"/> N <input type="checkbox"/> | Liver Disease                                   | Y <input type="checkbox"/> N <input type="checkbox"/> |   |   |
| Eating Disorder                | Y <input type="checkbox"/> N <input type="checkbox"/> | COPD/Emphysema                                  | Y <input type="checkbox"/> N <input type="checkbox"/> | Other: _____  |   |
| Epilepsy or Seizures           | Y <input type="checkbox"/> N <input type="checkbox"/> | Lupus   | Y <input type="checkbox"/> N <input type="checkbox"/> | _____   |   |

26. Are there any other conditions/diseases regarding your health history that we should be made aware of?

Y  N  \_\_\_\_\_

27. Do you wish to speak privately to the Doctor about any concern or medical condition? Y  N

**DENTAL HISTORY**

1. Is there a dental problem you would like treated immediately? Y  N  \_\_\_\_\_
2. Have you ever had any other following types of dental treatment? Choose All That Apply:  
Periodontal/Gum Therapy  \_\_\_\_\_ Orthodontics (Braces)  \_\_\_\_\_  
Removable Dental Appliances  \_\_\_\_\_ Oral Surgery  \_\_\_\_\_
3. Have you noticed any growths or sore spots in your mouth? Y  N  \_\_\_\_\_
4. Do your gums bleed or do you have pain/swelling of your gums? Y  N  \_\_\_\_\_
5. Have you noticed any loose teeth or have any teeth moved or shifted? Y  N  \_\_\_\_\_
6. Do you have any areas where food catches between your teeth? Y  N  \_\_\_\_\_
7. Are any of your teeth sensitive (hot, cold, sweets or pressure)? Y  N  \_\_\_\_\_
8. Have you ever been advised to take antibiotics before a dental appointment? Y  N  \_\_\_\_\_
9. How often do you brush your teeth? \_\_\_\_\_ Do you feel you have bad breath? Y  N

10. Do you use dental floss or any other dental aids? Y  N  *If yes, how often?* \_\_\_\_\_

11. Do you have any of the following jaw/jaw joint problems? Choose All That Apply:

Popping / Clicking  Pain in the jaw, side of face, ears  Pain/Difficulty Opening/Closing/Chewing   
Pain when teeth clenched  Bite Adjusted to Treat a Jaw Problem

12. Do you have any of the following habits? Choose All That Apply:

Clenching/Grinding Teeth  Biting Cheeks/Lips  Excessive Mouth Breathing   
Snoring  Chewing/Biting Fingernails/Pens/Foreign Objects

13. If you could change anything about your smile, what would it be? \_\_\_\_\_

14. How would you rate your dental anxiety? HIGH  MODERATE  LOW  NONE

15. (a) Have you ever been sedated for dental treatment? Y  N

*If yes, When?* \_\_\_\_\_ *Where?* \_\_\_\_\_

(b) Do you feel that you would like to be sedated for any needed treatment? Y  N

16. Have you ever had a bad dental experience or any complications with dental treatment? Y  N

\_\_\_\_\_

17. Are there any questions you have at this time? Y  N

\_\_\_\_\_

**NEW PATIENTS ONLY:** Have you been seeing a dentist regularly? Y  N

Date of last dental visit & type of treatment: \_\_\_\_\_

Are you being followed up by any dental specialists? Y  N  Name: \_\_\_\_\_

***In the event of an emergency, please contact the following person on my behalf:***

**Name:** \_\_\_\_\_ **Number:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**General Release Statement**

I, the undersigned, certify that I have provided an accurate and complete personal and health history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my health and dental history. Should there be any change in either my health status or any other information I have provided, I will advise the dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or other health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidance of the policy. I understand that responsibility for payment of the dental services for myself and dependents is mine and I assume responsibility for fees associated with these services.

**Signature:** \_\_\_\_\_