NAME_____ MARITAL STATUS_____AGE_____
SOCIAL SECURITY NUMBER_____BIRTH DATE _____SEX_____
ADDRESS_____CITY_____ST_____ZIP_____PHONE #_____
MOBILE PHONE_____ EMAIL ADDRESS_____
EMPLOYER_____EMPLOYER PHONE NUMBER _____
EMPLOYER ADDRESS_____
TITLE PREFERENCE: MR/MRS/TITLE/NICKNAME_____SCHOOL_____

PLEASE ANSWER ALL QUESTIONS:

1) ARE YOU IN GENERAL GOOD HEALTH?_____YES/NO
2) ARE YOU UNDER THE CARE OF A PHYSICIAN?_____YES/NO
3) PHYSICIAN'S NAME, ADDRESS AND NUMBER_____
_____
4) PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD:

( ) FAINTING SPELLS	( ) HEART TROUBLE	( ) EMPHYSEMA
( ) STROKE	( ) DIABETES	( ) LIVER DISEASE
( ) YELLOW JAUNDICE	( ) HEPATITIS	( ) SYPHILLIS
( ) VENEREAL DISEASE	( ) GONORRHEA	( ) AIDS
( ) ANEMIA	( ) TUBERCULOSIS	( ) TUMORS OR CANCER
( ) LOW BLOOD (SUGAR)	( ) ASTHMA	( ) HAY FEVER
( ) HIVES	( ) CHICKEN POX	( ) BLEEDING PROBLEMS
( ) ULCER (ANY TYPE)	( ) SICKLE CELL	( ) THYROID DISEASE
( ) MEASLES OR MUMPS	( ) KIDNEY DISEASE	( ) CONVULSIONS
( ) HIGH BLOOD PRESSURE	( ) RHEUMATOID ARTHRITIS	( ) RADIATION TREATMENT
( ) SCARLET FEVER	( ) EPILEPTIC SEIZURES	( ) RHEUMATIC FEVER
( ) MENTAL DISABILITIES	( ) EMOTIONAL PROBLEMS TREATED BY MEDICATION	( ) CORTISONE TX
( ) PHYSICAL DISABILITIES		

5) ARE YOU ON BLOOD THINNERS?_____YES/NO
6) ARE YOU CURRENTLY TAKING ANY MEDICATIONS?_____YES/NO
7) PLEASE LIST THEM:

MEDICINE	**DOSAGE (mg)**	**HOW TAKEN**	**FOR**

8) HAVE YOU HAD ANY WEIGHT LOSS IN THE RECENT MONTHS? _____YES/NO
9) **PLEASE LIST IF YOU HAVE HAD ANY ALLERGIC REACTION TO PENICILLIN OR OTHER MEDICATION YES/NO**
_____
10) DO YOU HAVE SHORTNESS OF BREATH UPON LYING DOWN OR CLIMBING A FLIGHT OF STAIRS?___YES/NO
11) DO YOU EVER FEEL NUMBNESS IN YOUR FEET OR LEGS?_____YES/NO
12) DO YOUR FEET OR LEGS SWELL? _____YES/NO
13) HAVE YOU BEEN TOLD YOU HAVE A HEART MURMUR OR AN ABNORMAL SOUNDING HEART?__ YES/NO
14) HAVE YOU HAD CHEST PAIN OR FELT THAT YOUR HEART WAS BEATING IRREGULARLY? _____YES/NO
15) DO YOU HAVE NOSE BLEEDS?_____YES/NO
16) ARE YOUR STOOLS BLACK?_____YES/NO
17) HAVE YOU EVER NOTICED BLOOD IN YOUR URINE?_____YES/NO
18) DO YOU SEEM TOO WARM OR COOL IN A ROOM WHERE EVERYONE ELSE FEELS COMFORTABLE? _YES/NO
19) DO YOU BRUISE OR BLEED EASILY?_____YES/NO
20) DO YOU HAVE SEVERE HEADACHES?_____YES/NO
21) IS THERE A HISTORY OF DIABETES (SUGAR) IN THE FAMILY?_____YES/NO
22) DO YOU PASS WATER MORE THAN SIX TIMES A DAY OR TWO TIMES AT NIGHT?_____YES/NO
23) HAVE YOU EVER USED DRUGS SUCH AS: HEROIN, COCAINE, CRACK, LSD, AND/OR MARIJUANA?___YES/NO
24) DO YOU SMOKE? _____YES/NO
25) DO YOU DRINK ALCOHOLIC BEVERAGES?_____YES/NO

PATIENT SIGNATURE_____DATE_____

26) HAVE YOU EVER HAD ULCERS IN YOUR MOUTH?_____YES/NO
27) HAVE YOU EVER HAD ANY (TMJ), JOINT PAIN UPON OPENING OR CLOSING YOUR MOUTH?_____ YES/NO
28) HAVE YOU EVER HAD ANY FACIAL PAIN OR INJURY TO YOUR FACE OR TO YOUR TEETH?_____ YES/NO
29) HAVE YOU EVER HEARD A CLICKING OR POPPING SOUND UPON OPENING OR CLOSING YOUR MOUTH? _____YES/NO
30) DO YOUR GUMS BLEED?_____YES/NO
31) DO YOU CLINCH OR GRIND YOUR TEETH AT NIGHT (BRUXISM)?_____YES/NO
32) HAVE YOU EVER HAD EXTENDED NUMBNESS AFTER DENTAL TREATMENT?_____ YES/NO
33) DO YOU HAVE A PACEMAKER OR HEART VALVE?_____YES/NO
34) DO YOU HAVE ANY TYPE OF PROSTHETIC APPLIANCES? (i.e., HIP OR LEG REPLACEMENT, ETC.)____YES/NO
35) IS THERE ANYTHING ABOUT YOUR HEALTH THAT THIS OFFICE SHOULD KNOW ABOUT THAT IS NOT COVERED ON THIS HEALTH HISTORY?_____YES/NO

WOMEN ONLY

36) DO YOU HAVE IRREGULAR MENSTRUAL PERIODS?_____YES/NO
37) ARE YOU ON BIRTH CONTROL PILLS?_____YES/NO
38) HAVE YOU HAD EXCESSIVE BLEEDING IN THE LAST TWO YEARS?_____YES/NO
39) HAVE YOU STOPPED MENSTRUATING (MENOPAUSE)?_____YES/NO
40) ARE YOU PREGNANT?_____HOW MANY MONTHS?_____

MEN ONLY

41) HAVE YOU EVER BEEN TOLD YOU HAVE A PROSTRATE CONDITION?_____YES/NO
IF YOU ANSWERED YES TO 41, ARE YOU ON MEDICATION?_____YES/NO
IF SO, WHAT IS THE NAME OF THE MEDICATION?_____

CHILDREN ONLY

42) IS THIS YOUR CHILD'S FIRST DENTAL VISIT?_____YES/NO
43) HAS YOUR CHILD HAD DIFFICULTY IN ACCEPTING DENTAL TREATMENT?_____YES/NO
44) HAS YOUR CHILD EVER HAD FLUORIDE?_____YES/NO
45) HAS YOUR CHILD EVER HAD FLUORIDE IN DROPS OR VITAMINS?_____YES/NO
46) IS THERE FLUORIDE IN THE WATER WHERE YOU LIVE?_____YES/NO
47) DOES YOUR CHILD LIKE TO BRUSH HIS OR HER TEETH?_____YES/NO
48) DO YOU HELP YOU CHILD BRUSH HIS OR HER TEETH?_____YES/NO
49) IF YOUR CHILD IS UNDER THE AGE OF THREE IS HE OR SHE STILL ON THE BOTTLE?_____YES/NO

PATIENT SIGNATURE_____**DATE**_____
(IF PATIENT A MINOR, PARENT'S SIGNATURE)

PATIENT SIGNATURE_____**DATE**_____
(IF PATIENT A MINOR, PARENT'S SIGNATURE)

PATIENT SIGNATURE_____**DATE**_____
(IF PATIENT A MINOR, PARENT'S SIGNATURE)

PATIENT SIGNATURE_____**DATE**_____
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