Name: Date:

Medical History

		Yes	No	Comments (D.D.S.)
1	Rheumatic Fever			
2	Heart Murmur			
3	Abnormal Heart Condition			
4	Heart Attack			Year:
5	Pacemaker			
6	Artificial Joints			
7	High Blood Pressure			BP Today /
8	Blood Disorder			
9	Healing Complications			
10	Epilepsy/Seizures			
11	Diabetes			
12	Hepatitis			Year: Type:
13	Contact with AIDS			
14	Kidney Disease			
15	Resp. Disease/TB/ Asthma/Hay Fever			
16	Arthritis			
17	Ulcers			
18	Canker Sores/Cold Sores			
19	Chemically Dependent			
20	Taking Drugs or Medications			
21	Do You Smoke or Use Tobacco?			
22	Presently Under Care of M.D.			Physician's Name:
23	Do you have any current medical problems?			
24	Allergies to Drugs or Medications?			
25	Any Other Allergies?			
26	Women: Pregnant Now?			
27	Blood Transfusion?			
28	Had a Complete Physical?			Year:
29	Any Major Surgeries:			

Dental History

1. Reason for this visit? _____
2. Date/year last treated? _____
3. Last Dentist visited? _____
4. How often do you brush? _____ floss? _____
5. Do you clench or grind your teeth? _____
6. Any sensitive teeth? Hot, cold, sweets or chewing? _____ Where? _____
7. Does food catch between your teeth? _____
8. Do your gums bleed? _____ Where? _____
9. Any loose teeth? _____ Where? _____
10. Do you prefer an anesthetic for dental treatment? _____
11. Do you prefer nitrous oxide for dental treatment? _____
12. Are you satisfied with your previous dentistry? _____
13. Additional comments: _____

Children Only:

1. Is this your child's first dental visit?
   ☐ Yes ☐ No
   If "No" give approximate date of last dental visit? _____
2. Do you have city water? ☐ Yes ☐ No ☐ Don't know

Parent/Guardian Signature

Date	Medical History Change	Pt. Initial	BP	Date	Medical History Change	Pt. Initial	BP

HEALTH EVALUATION