Name _____ **D.O.B.** _____ **SS#** _____

Address _____ **Date** _____

E-Mail Address _____ **Home Tel.** _____

Referred by _____ **Occupation** _____ **Work Tel.** _____

A. Are you here for Emergency treatment? ❑ **YES** ❑ **NO**

B. Are you in pain? ❑ **YES** ❑ **NO**

C. Are you in good health? ❑ **YES** ❑ **NO**

D. Has there been any change in your general health within the past 5 years? ❑ **YES** ❑ **NO**

E. Please list your oral complaint: _____

_____

Prior Dentist's name & address _____

F. Do you have a physician (M.D.)? ❑ **YES** ❑ **NO**

Physician's name: _____ Phone: _____

Address _____

G. Date of last dental exam: _____ **H.** Date of last full mouth X-Rays: _____

I. Date of last medical X-Rays: _____ (Last Chest X-Ray) _____

J. Have you ever had any of the following conditions?:	**YES**	**NO**
1. Rheumatic heart disease?	❑	❑
2. Heart murmur, mitral valve prolapse?	❑	❑
3. Congenital heart disease?	❑	❑
4. Prosthetic heart valve?	❑	❑
5. Angina?	❑	❑
6. Heart attack?	❑	❑
7. Irregular heart beat?	❑	❑
8. Pacemaker?	❑	❑
9. Shortness of breath after mild activity or when you lie down?	❑	❑
10. High blood pressure?	❑	❑
11. Swollen ankles?	❑	❑
12. Asthma?	❑	❑
13. Emphysema or difficult breathing?	❑	❑
14. Seizures or convulsions?	❑	❑
15. Psychiatric treatment?	❑	❑
16. Radiation therapy/Chemotherapy?	❑	❑
17. Blood disorder or bleeding tendency or frequent brusing?	❑	❑
18. Stomach ulcer?	❑	❑
19. Diabetes?	❑	❑
20. Recent increase in urination or thirst?	❑	❑
21. Thyroid problem?	❑	❑
22. Unexplained weight loss in the past year?	❑	❑
23. Kidney problem?	❑	❑
24. Renal dialysis?	❑	❑
25. Hepatitis?	❑	❑
26. Liver disease?	❑	❑
27. HIV infection?	❑	❑
28. Venereal disease/syphillis/gonorrhea?	❑	❑
29. Pelvic inflammatory disease?	❑	❑
30. Tuberculosis?	❑	❑
31. Persistent cough, coughing up blood?	❑	❑
32. PPD positive?	❑	❑
33. Enlarged lymph nodes/swollen glands?	❑	❑
34. Autoimmune disease?	❑	❑
35. Lupus Erythematosus?	❑	❑
36. Arthritis? Rheumatism?	❑	❑
37. Prosthetic joint?	❑	❑
38. Do you have any allergies?	❑	❑

Explain _____

_____

_____

Women:

39. Are you pregnant?	❑	❑
40. Are you taking birth control pills?	❑	❑

LIST ALL MEDICATIONS YOU ARE NOW TAKING _____

_____

Have you ever had any of the following oral conditions?:	**YES**	**NO**		**YES**	**NO**
Dry mouth (xerosatomia)?	❑	❑	Burning in the mouth?	❑	❑
Offensive breath (halitosis)?	❑	❑	Sores in the mouth?	❑	❑
Thrush in the mouth (candidiasis)?	❑	❑	Chronic mouth/gum bleeding?	❑	❑

I hearby affirm the forgoing information to be correct:

Signature _____ Date _____