General Health History

Name_____ Birth date_____ Age_____

Name of physician_____ Telephone_____ Date of last physical_____

Are you presently taking any medications? Type and amount_____

_____

Do you use marijuana or other "street" drugs ..... Y N

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

Are you now under a physician's care for a particular problem? ..... Y N

Reason_____

Have you had any serious illnesses, operations or hospitalizations? List _____ Y N

_____

Are you Allergic or Have you had a Reaction to:

Local anesthetic ..... Y N

Other medications ..... Y N

Latex ..... Y N

Do you have or have you ever had:

Seizures, convulsions, epilepsy, fainting, stroke, CVA or dizziness ..... Y N

Nervous disorder, breakdown or psychiatric treatment ..... Y N

Glaucoma ..... Y N

Sinus or nasal problems ..... Y N

Thyroid disease ..... Y N

Rheumatic fever or rheumatic heart disease ..... Y N

Congenital heart disease ..... Y N

Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, stroke, palpitations, heart surgery, pacemaker) ..... Y N

High blood pressure ..... Y N

Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing) ..... Y N

Bleeding disorder, anemia, bleeding tendency, blood transfusion ..... Y N

Liver disease (jaundice or hepatitis) ..... Y N

Stomach ulcers, colitis, or gastric reflux ..... Y N

Kidney disease ..... Y N

Diabetes ..... Y N

Arthritis ..... Y N

Osteoporosis ..... Y N

Frequent or recurring mouth sores ..... Y N

Implants placed anywhere in body (heart, valve, hip, knee) ..... Y N

Cancer ..... Y N

Radiation (x-ray) treatment for cancer of the head, mouth or neck ..... Y N

Any disease, drugs, or transplant operation that has depressed your immune system ..... Y N

Herpes ..... Y N

Venereal diseases ..... Y N

AIDS ..... Y N

Weight gain or loss of more than 10 lbs. in the last year .....Y N

Do you smoke or use tobacco products, If yes how much and how often?_____ .....Y N

Do you use alcohol, If yes how much and how often ?_____ .....Y N

Women Are you Pregnant? What week or month_____ .....Y N

How long since your last dental visit_____ What was done_____

Are you in any discomfort at this time?_____

Date of last dental x-rays_____ Office taken in_____

How long since your last professional dental cleaning?_____

Are you happy with the way your teeth look?_____

Do you have any fear of having dentistry?_____ If yes, why?_____

Have you lost any teeth?_____ Why?_____

Any complications with extractions?_____

Do your gums bleed? _____ When? _____

Do you have clicking or popping of the jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?_____

Do you have a history of headaches? _____ When_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

Signature of Patient, Parent or Guardian_____**Date**_____

Doctor's Notes: