9. Do you have or have you ever had any of the following?

Heart Failure	Yes	☐	No	☐	Tumors or growths	Yes	☐	No	☐
Heart Disease or Attack	Yes	☐	No	☐	Cancer	Yes	☐	No	☐
Angina Pectoris	Yes	☐	No	☐	X-Ray/Cobalt Treatment	Yes	☐	No	☐
High Blood Pressure	Yes	☐	No	☐	Chemotherapy	Yes	☐	No	☐
Heart Murmur/MVP	**Yes**	☐	No	☐	Arthritis	Yes	☐	No	☐
If so, do you Pre-Medicate for Dental Tx?	**Yes**	☐	**No**	☐	Cortisone Medicine	Yes	☐	No	☐
Rheumatic Fever	Yes	☐	No	☐	Pain in Jaw Joints	Yes	☐	No	☐
Congenital Heart Lesions	Yes	☐	No	☐	Glaucoma	Yes	☐	No	☐
Scarlet Fever	Yes	☐	No	☐	Aids	Yes	☐	No	☐
Damaged /Artificial Heart Valve	Yes	☐	No	☐	Hepatitis A (Infectious)	Yes	☐	No	☐
Heart Pacemaker	Yes	☐	No	☐	Hepatitis B (Serum)	Yes	☐	No	☐
Heart Surgery	Yes	☐	No	☐	Liver Disease	Yes	☐	No	☐
Implants/Artificial Joint	**Yes**	☐	No	☐	Yellow Jaundice	Yes	☐	No	☐
If so, do you Pre-Medicate for Dental Tx?	**Yes**	☐	**No**	☐	Blood Transfusion	Yes	☐	No	☐
Stroke	Yes	☐	No	☐	Drug Addiction	Yes	☐	No	☐
Kidney Trouble	Yes	☐	No	☐	Hemophilia	Yes	☐	No	☐
Ulcers	Yes	☐	No	☐	Venereal Disease				
Emphysema	Yes	☐	No	☐	(Syphilis, Gonorrhea)	Yes	☐	No	☐
Cough	Yes	☐	No	☐	Cold Sores	Yes	☐	No	☐
Tuberculosis (TB)	Yes	☐	No	☐	Epilepsy or Seizures	Yes	☐	No	☐
Asthma	Yes	☐	No	☐	Fainting or Dizzy Spells	Yes	☐	No	☐
Allergy, Hay Fever, Sinus	Yes	☐	No	☐	Psychiatric Treatment	Yes	☐	No	☐
Metal Sensitivity	Yes	☐	No	☐	Sickle Cell Disease	Yes	☐	No	☐
Diabetes	Yes	☐	No	☐	Bruise Easily	Yes	☐	No	☐
Anemia	Yes	☐	No	☐	Thyroid Disease	Yes	☐	No	☐

10. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor said you couldn't do? If so, please explain:_____

DENTAL HISTORY

1. Reason for this visit?_____
2. Last dental visit?_____ Purpose?_____ Last complete exam?_____
3. Do you prefer a local anesthetic (Novocain) for most dental treatment? Yes ☐ No ☐
4. Have you ever had any serious trouble associated with previous dental treatment?_____
5. Does dental treatment make you nervous? No ☐ Slightly ☐ Moderately ☐ Extremely ☐
6. Have you ever been treated for periodontal disease (Gum Disease, Pyorrhea, Trench Mouth)? Yes ☐ No ☐
   If so, when?_____

7. Do you have or have you ever had the following?

Bleeding/Sore Gums	Yes	☐	No	☐	Loose Teeth	Yes	☐	No	☐
Unpleasant Taste/Bad Breath	Yes	☐	No	☐	Sensitive to Hot	Yes	☐	No	☐
Burning Tongue/Lips	Yes	☐	No	☐	Sensitive to Cold	Yes	☐	No	☐
Frequent Blisters, Lips/Mouth	Yes	☐	No	☐	Sensitive to Sweets	Yes	☐	No	☐
Swelling/Lumps in Mouth	Yes	☐	No	☐	Sensitive to Biting	Yes	☐	No	☐
Ortho Treatment (Braces)	Yes	☐	No	☐	Food Impaction	Yes	☐	No	☐
Biting Cheeks/Lips	Yes	☐	No	☐	Clenching/Grinding	Yes	☐	No	☐
Clicking/Popping Jaw	Yes	☐	No	☐	Complications from Extractions	Yes	☐	No	☐
Difficulty Opening or Closing Jaw	Yes	☐	No	☐	Smoking (Cigarettes. Pipe, Cigar)	Yes	☐	No	☐

APPOINTMENTS: Please keep in mind that your appointment time is reserved especially for you, so we would appreciate the courtesy of a 24-hour advance notice for any cancellations. Thank you.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

Signature (Parent or Guardian, if Patient is a minor):_____ **Date:**_____

Dentist Signature:_____ **Date:**_____