G.I. AND G.U.:

30. Have you ever had hepatitis? If so, what type? _____ Yes No
31. Are you on any special diet? If so, what kind? _____ Yes No
32. Have you any kidney or liver problems? If so, specify _____ Yes No
33. Have you ever had syphillis, gonorrhea, or other venereal disease? ..... Yes No

OTHER:

34. Have you ever received X-ray or radioactive isotope treatment? ..... Yes No
35. Have you ever had a tumor or cancer? If so, what type? _____ Yes No
36. Have you ever had local anesthesia? ☐ general anesthesia? ☐ nitrous oxide (laughing gas)? ☐ ..... Yes No
37. Do you have arthritis? ..... Yes No
38. Do you have any impairment or disorder of your eyes, ears, nose or throat? ..... Yes No
39. Do you have recurrent herpes? ..... Yes No

FEMALES:

40. Are you now pregnant or are you anticipating pregnancy within the next year? ..... Yes No
41. Have you undergone ☐, or are you presently undergoing ☐, menopause? ..... Yes No
42. Are you taking birth control medication? ☐ hormone replacement therapy? ☐ ..... Yes No

PRESENT DENTAL HEALTH:

1. Name and address of your dentist _____
   _____ Phone _____
   Approximate date of initial visit _____ Date of most recent visit _____
2. Do your gums bleed? ..... Yes No
   If so, when? _____
3. Are you aware of a bad taste or odor in your mouth? ..... Yes No
4. Does your jaw ever click or cause pain upon opening or closing? ..... Yes No
5. Have you noticed any shift in your teeth or bite? ..... Yes No
6. Do you ever have pain in your jaw? ☐ in your ear? ☐ ..... Yes No
7. Have you ever noticed yourself clenching your teeth? ☐ grinding your teeth? ☐ ..... Yes No
   If so when? _____
8. Are any areas of your mouth sore or sensitive to pressure or irritants? ..... Yes No
   If so, where and to what? _____
9. Are you in pain now? If so, where? _____ Yes No
10. When were your last full mouth X-rays? _____
11. When did you last have your teeth cleaned? _____
    Where? _____
12. What oral hygiene aids do you use? _____
    How often? _____
13. What do you consider most important?
    preservation of natural teeth ☐ eradication of infection ☐ esthetics ☐
    elimination of pain ☐ avoidance of removable dentures ☐ function ☐
    other _____

PAST DENTAL HISTORY:

14. Have you ever had an acute sore mouth? ☐ gum boils? ☐ ..... Yes No
15. Did you ever have treatment to straighten your teeth? ..... Yes No
16. Have you ever been instructed in the care of your gums or prevention of decay? ..... Yes No
17. Have you ever had previous periodontal or gum treatments? ..... Yes No
    If so, when? _____ Where? _____
18. Have you ever had a tooth removed? ..... Yes No
    If so, when? _____ Why? _____
19. Have you ever had any serious problems associated with previous dental treatments? ..... Yes No
    If so, explain _____
20. Do you have any disease, condition, or problem not listed above that you think we should know about? ..... Yes No
    If so, explain _____

Signature _____ Date _____