GENERAL HEALTH CHART

Name _____ Social Security # _____

Address _____ City _____ Zip _____ Phone _____

E-mail _____ Fax _____ Mobile Phone _____

I would prefer to be addressed as _____ Referred By _____ Marital Status _____

Age _____ Date of Birth _____ Sex _____ Height _____ Weight _____ Spouse's Name _____

Occupation _____ Employer _____

Address _____ City _____ Zip _____ Phone _____

Most convenient: Appointment time _____ Contact time _____ Contact mode _____

PRESENT HEALTH:

1. How would you describe your present health? _____
2. Are you now under the care of a physician? ..... Yes No
3. Names, addresses, phone numbers, and specialties of all of your physicians _____
   _____
   _____
   _____
4. What medications, prescription and non-prescription, are you presently taking? _____
   _____
5. Are you sensitive to aspirin ☐, penicillin ☐, novocaine ☐, codeine ☐, or any other drug? ..... Yes No
   If so, describe _____
6. Do you require antibiotic premedication prior to dental care? ..... Yes No
7. Are you, or do you have any reason to believe you may be, HIV positive? ..... Yes No

PAST MEDICAL HISTORY:

8. Have you had any serious illness or operation? ..... Yes No
   If so, what and when? _____
9. Have you ever had any allergies? ..... Yes No
   If so, what and when? _____
10. Are you now taking, or have you ever taken, medication to prevent osteoporosis? ..... Yes No
    If so, what and when? _____

CARDIOVASCULAR:

11. Have you ever had any heart conditions? ☐ murmurs? ☐ ..... Yes No
12. Has your blood pressure ever been too high? ☐ too low? ☐ ..... Yes No
13. Have you ever had rheumatic fever? ☐ rheumatic heart disease? ☐ ..... Yes No
14. Are you subject to fainting spells? ☐ dizziness? ☐ chest pains? ☐ ..... Yes No
15. Have you ever had a stroke? ..... Yes No

HEMATOLOGY:

16. Have you ever had abnormal bleeding problems after a cut? ☐ tooth extraction? ☐ ..... Yes No
17. Do you bruise easily? ☐ bleed easily? ☐ ..... Yes No

ENDOCRINE:

18. Do you have diabetes? ..... Yes No
19. Have you ever received treatment for any endocrine or glandular disease? ..... Yes No

NEUROLOGY:

20. Do you suffer from frequent or severe headaches? ..... Yes No
21. Have you ever had severe pains of the head or face? ..... Yes No
22. Do you consider yourself excessively nervous? ..... Yes No
23. Have you ever had epilepsy or seizures? ..... Yes No
24. Have you ever suffered from depression? ..... Yes No

RESPIRATORY:

25. Do you ever become short of breath? ..... Yes No
26. Do you have asthma? ☐ emphysema? ☐ ..... Yes No
27. Have you had tuberculosis or a persistent cough? ..... Yes No
28. Do you smoke? If so, what and how much? _____ Yes No
29. Do you have sinus problems? If so, what kind? _____ Yes No

(COMPLETE OTHER SIDE)

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 _____