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? ☐ TIA? ☐ .... 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 ______