

# GENERAL HEALTH INFORMATION CHART # \_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ LAST \_\_\_\_\_ FIRST \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_

## DENTAL HISTORY

1. Reason for Visit / Main Concern? Check-Up  Cleaning  Toothache  Other \_\_\_\_\_
2. Are there other conditions of which we should be aware? YES  NO  If yes, please specify: \_\_\_\_\_
3. When did you last visit a dentist? \_\_\_\_\_
4. What treatment was performed? \_\_\_\_\_
5. Was the treatment completed? \_\_\_\_\_
6. When were dental x-rays taken? \_\_\_\_\_
7. Did you have a cleaning? YES  NO
8. Have you had gum (periodontal) treatment? YES  NO
9. Have you ever had prolonged bleeding after an extraction? YES  NO  If yes, please specify: \_\_\_\_\_
10. Have you had any problems with past dental treatment? YES  NO  If yes, please specify: \_\_\_\_\_
11. Do you grind your teeth, clench your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES  NO  If yes, please specify: \_\_\_\_\_
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES  NO  If yes, please specify: \_\_\_\_\_
13. Do your gums bleed easily? YES  NO
14. Do you feel you have bad breath? YES  NO
15. Are your teeth sensitive to hot or cold? YES  NO
16. Would you like your teeth whiter? YES  NO
17. Are you happy with your smile? YES  NO  If no, please explain: \_\_\_\_\_

## MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES  NO  If yes, please specify: \_\_\_\_\_ Dr. Name: \_\_\_\_\_  
Dr. Phone: ( ) \_\_\_\_\_
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? \_\_\_\_\_
3. Are you taking any medications at this time, including birth control? YES  NO  If yes, please specify: \_\_\_\_\_
4. (Woman) Are you pregnant at this time? YES  NO  If yes, please specify how many months: \_\_\_\_\_
5. Are there any other health problems of which we should be advised? Please specify: \_\_\_\_\_
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"	Doctor Comments	Please check "YES" or "NO"	Doctor Comments
ARTIFICIAL Heart Valve	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	HEPATITIS	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
AIDS/HIV+	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	HIGH BL. PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
ANEMIA	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	JAUNDICE	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
ANGINA	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	JOINT REPLACEMENT	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
ARTHRITIS	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	KIDNEY DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
ASTHMA	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	LATEX ALLERGY	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
BLEEDING PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	LIVER PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
CANCER	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	LOW BL. PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
CHEMO/RAD THERAPY	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	LUNG DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
COSMETIC SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	PACEMAKER	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
DIABETES	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	PHEN-FEN	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
DIZZY SPELLS	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	PSYCHIATRIC CARE	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
DRUG ADDICTION	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	RHEUMATIC FEVER	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
EMPHYSEMA	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	SINUS TROUBLE	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
EPILEPSY	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	SLEEP APNEA	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
FAINTING	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	SMOKING TOBACCO	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
GLAUCOMA	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	STROKE	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
HEART ATTACK	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	THYROID PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
HEART SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	TMD OR TMJ	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
HEART MURMUR	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	TUBERCULOSIS	YES <input type="checkbox"/> NO <input type="checkbox"/> _____
HEART PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/> _____	VENEREAL DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/> _____

*To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.*

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent if Patient is a Minor)

Doctor Signature \_\_\_\_\_

## MEDICAL UPDATE:

1. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_
2. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_
3. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_