HEALTH & DENTAL QUESTIONS

☐ YES ☐ NO Would you like whiter teeth? (If yes, please ask the staff for information)
☐ YES ☐ NO Is your general health good?
☐ YES ☐ NO Do you have any allergies to any foods, medications, metals, latex or earrings?
If so, which ones?____________________

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

- ☐ YES ☐ NO Heart trouble?
- ☐ YES ☐ NO Heart murmur?
- ☐ YES ☐ NO Mitral valve prolapse?
- ☐ YES ☐ NO Leaky heart valve?
- ☐ YES ☐ NO Infective endocarditis?
- ☐ YES ☐ NO Artificial (prosthetic) heart valve or valves?
- ☐ YES ☐ NO Asthma?
- ☐ YES ☐ NO Bleeding problems?
- ☐ YES ☐ NO Epilepsy?
- ☐ YES ☐ NO Hepatitis?
- ☐ YES ☐ NO Females: are you pregnant?
- ☐ YES ☐ NO Artificial (prosthetic) joints?

If yes, when was the artificial joint placed?____________________

- ☐ YES ☐ NO Infected artificial joint?
- ☐ YES ☐ NO Hemophilia?
- ☐ YES ☐ NO Malnourishment?
- ☐ YES ☐ NO Systemic lupus erythematosus?
- ☐ YES ☐ NO Rheumatoid arthritis?
- ☐ YES ☐ NO Osteoporosis?

If yes, what medications are you taking?____________________

- ☐ YES ☐ NO Rheumatic fever or Scarlet fever?
- ☐ YES ☐ NO HIV or AIDS?
- ☐ YES ☐ NO Immunosuppression?
- ☐ YES ☐ NO Radiation therapy?
- ☐ YES ☐ NO Diabetes?
- ☐ YES ☐ NO Bleeding gums?
- ☐ YES ☐ NO Dry mouth?
- ☐ YES ☐ NO Problems associated with grinding your teeth?
- ☐ YES ☐ NO Swollen or tender gums?
- ☐ YES ☐ NO Periodontal / gum treatment?
- ☐ YES ☐ NO Sensitivity to hot / cold?
- ☐ YES ☐ NO Clicking or popping of jaw or joint pain near ear?
- ☐ YES ☐ NO High blood pressure?
- ☐ YES ☐ NO Pacemaker?
- ☐ YES ☐ NO Is there any other information about your health which should be known?

If so, what?____________________

Please list ALL current medications? ____________________

____

Physician name, address and telephone (if known) ____________________

____

Patient Name:

____________________ Date __________

Signed (patient or parent if minor)

UPDATES (For office use only)

Any Changes?	YES	NO	If so, what? ____________________	Date: _______	Initials: _____
Any Changes?	YES	NO	If so, what? ____________________	Date: _______	Initials: _____
Any Changes?	YES	NO	If so, what? ____________________	Date: _______	Initials: _____
Any Changes?	YES	NO	If so, what? ____________________	Date: _______	Initials: _____
Any Changes?	YES	NO	If so, what? ____________________	Date: _______	Initials: _____