Have you had, or do you now have:

	Yes	No		Yes	No
High/low blood pressure	___	___			
AIDS	___	___	Herpes	___	___
Allergies	___	___	Jaundice	___	___
Anemia	___	___	Joint Replacement	___	___
Angina	___	___	Kidney Disease	___	___
Arthritis	___	___	Liver Disease	___	___
Artificial heart valves	___	___	Organ Transplant	___	___
Artificial joints	___	___	Pacemaker	___	___
Asthma	___	___	Prolonged bleeding	___	___
Cancer	___	___	Prolonged cough	___	___
Chemotherapy	___	___	Psychiatric treatment	___	___
Congenital heart lesions	___	___	Radiology therapy	___	___
Diabetes	___	___	Rheumatic fever	___	___
Drug Dependency	___	___	Sickle Cell Anemia	___	___
Easily bruised	___	___	Sinus/Hay Fever	___	___
Epilepsy/Neurological problems	___	___	Stroke	___	___
Fainting or dizzy spells	___	___	Thyroid Disease	___	___
Glaucoma or eye problems	___	___	Tonsillitis	___	___
Heart disease	___	___	Tuberculosis/Lung disease	___	___
Heart murmur	___	___	Ulcers	___	___
Hepatitis	___	___	Venereal Disease	___	___

Have you any disease, condition, or problem not previously listed? _____

_____

DENTAL HEALTH

When was your last dental visit? _____ Who did you see? _____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort:

Hot___ Cold___ Sweets___ Chewing___

How often do you brush your teeth? _____ How often do you floss? _____

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Have you had periodontal treatment? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Does it ever click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____

Do you have frequent headaches? _____ Ear aches? _____

Have you ever had orthodontic treatment (i.e. braces?)_____ When? _____

Do you lose or break fillings?_____ Do you usually have many cavities? _____

Do you have any loose teeth? ____Cracked or broken teeth? _____Food traps? _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? ___Fixed bridge ___Removable Partial ___Full denture ___Implant

Are you comfortable with the replacement? Please describe _____

_____