

Date: \_\_\_\_\_

Referred By: \_\_\_\_\_

**PATIENT'S HISTORY AND INFORMATION**

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_  
RES. ADDRESS: \_\_\_\_\_ RES. PHONE: \_\_\_\_\_  
CITY/STATE/ZIP \_\_\_\_\_  
BUS. ADDRESS: \_\_\_\_\_ BUS. PHONE: \_\_\_\_\_  
EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
SPOUSE'S NAME: \_\_\_\_\_ SPOUSE'S BUS. PHONE: \_\_\_\_\_  
PHYSICIAN: \_\_\_\_\_ PHYSICIAN'S PHONE: \_\_\_\_\_  
SOCIAL SECURITY #: \_\_\_\_\_

**DIRECTIONS: Please answer the questions below by circling YES or NO. If any of the answers are YES, please explain in detail at the bottom.**

- |  |    |     |
|--|----|-----|
| 1) Have you ever had a serious illness?  | NO | YES |
| 2) Have you ever been hospitalized or had an operation?  | NO | YES |
| 3) Are you HIV positive or do you have AIDS?   | NO | YES |
| 4) Have you ever had an unusual or allergic reaction to any drugs or medications?  | NO | YES |
| 5) Are you currently taking any medication?  | NO | YES |
| 6) Have you ever had rheumatic fever?  | NO | YES |
| 7) Have you had a heart attack?  | NO | YES |
| 8) Have you ever been told that your blood pressure was too high or too low?   | NO | YES |
| 9) Do you have a heart murmur (leaky valve)?   | NO | YES |
| 10) Do you have any sinus or respiratory problems?   | NO | YES |
| 11) Have you had jaundice (yellow eyes or skin)?   | NO | YES |
| 12) Have you ever had liver disease (hepatitis)?   | NO | YES |
| 13) Have you ever had syphilis or any other venereal disease?  | NO | YES |
| 14) Do you have a problem with headaches?  | NO | YES |
| 15) Have you ever had diabetes?  | NO | YES |
| 16) Are you frequently weak when you do not eat on schedule?   | NO | YES |
| 17) Do you have any illness or disease not previously mentioned?   | NO | YES |
| 18) Are you pregnant?  | NO | YES |
| 19) Have you ever had any trouble associated with previous dental treatment ?<br>(dizziness, fainting, or reaction to novocaine) | NO | YES |
| 20) Do your gums ever bleed?   | NO | YES |
| 21) Do you notice any clicking or popping noises in your jaw?  | NO | YES |
| 22) Do you awaken with sore jaws or sore teeth?  | NO | YES |
| 23) Have you ever had severe pains of the face or head?  | NO | YES |
| 24) Do you ever experience bad breath?   | NO | YES |
| 25) Do you frequently have a bad taste in your mouth?  | NO | YES |
| 26) Are you satisfied with your smile?   | NO | YES |

Please Explain Any YES Answers:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature: