MEDICAL HISTORY

Please check the following for which the patient has been treated:

YES	NO		YES	NO		YES	NO	
☐	☐	Diabetes	☐	☐	Convulsions/Epilepsy	☐	☐	Nervous Disorders
☐	☐	Pneumonia	☐	☐	Asthma, Hay Fever, Allergies	☐	☐	Endocrine Problem
☐	☐	Heart Troubles	☐	☐	Anemia	☐	☐	Fainting or Dizzy Spells
☐	☐	Rheumatic Fever	☐	☐	Prolonged Bleeding	☐	☐	Adenoids Removed Age___
☐	☐	Tuberculosis	☐	☐	Bone Disorders	☐	☐	Tonsils Removed Age___
☐	☐	Pregnancy	☐	☐	Frequent Colds and/or Flu	☐	☐	Hepatitis

List any other serious illnesses or medical problems________________________________

List any allergies (including those to any drugs or medications)________________________________

List any drugs or medications now being taken________________________________

DENTAL HISTORY

	YES	NO
Do you clench or grind your teeth (at night)?................................	☐	☐
Do you have pain or clicking upon opening or closing your mouth?	☐	☐
Have you had any severe injuries to your head, face or teeth?.......	☐	☐
Do you suffer from a frequent sore neck or headaches?.................	☐	☐
Have any teeth been injured or chipped due to accidents?.............	☐	☐
Have you been informed of any extra or missing permanent teeth?	☐	☐
Is there a noticeable difficulty in chewing or swallowing food?.......	☐	☐
WOULD YOU MIND WEARING BRACES?.......................................	☐	☐
Are you aware of any tongue thrusting problems?.........................	☐	☐
Do you have periodontal (gum) disease?......................................	☐	☐
Date of last Dental appointment________Were X-rays taken?........	☐	☐

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Patient's Signature