GENERAL INFORMATION AND MEDICAL HISTORY

Name_____

In order to evaluate your health in relationship to your dental needs, please answer the following questions by writing YES, NO, or "?", if you do not know, in the space provided.

1. Have you had previous periodontal treatment? _____

2. How often have you had your teeth cleaned in the last 3 years?_____ Last time? _____

3. Do you consider your medical health to be: GOOD _____ FAIR _____ POOR _____

4. Have you been treated by a physician or hospitalized during the past five years?_____

5. Do you have any artificial prostheses such as: hip replacement, artificial joint, heart valve? _____

6. Are you taking any medicine, drugs or pills such as: vitamins, tranquilizers, insulin, anticoagulants, etc.? _____

_____

7. Are you allergic to any medicines or drugs such as: Antibiotics, Aspirin, Codeine, Novocaine, Penicillin, Demerol, Antihistamines, Barbiturates, Others?_____

8. Have you ever had any of the following:

Anemia_____	Kidney Trouble _____	Hepatitis_____
Heart Disease_____	Stroke_____	Swollen Ankles _____
Heart By-Pass _____	Excessive Thirst _____	Psychiatric Treatment _____
Heart Murmur _____	Liver Trouble_____	Bleeding Problems_____
Congenital Heart Problems _____	Gland Trouble _____	Venereal Disease _____
Diabetes _____	Bladder Trouble_____	Glaucoma_____
Arthritis _____	Low Blood Pressure _____	Epilepsy_____
Lung Trouble_____	High Blood Pressure _____	Allergy_____
Rheumatic Fever _____	Chest Pains _____	Fever Blisters_____
Ulcer _____	Tumor or Growth_____	Grinding/Clenching Teeth_____

9. Do you have any reason to believe that you may be immunosuppressed (chemotherapy, transplant surgery, failure of your immune system, etc.)? _____

10. Would you be tremendously disturbed if you had to wear false teeth? _____

11. What is the name of your medical doctor or doctors? _____

12. When was your last physical examination? _____

13. Do you consider yourself a nervous person? _____Have you been under strain lately? _____

14. Do you smoke? _____How much?_____ 15. Do you have headaches often?_____

16. Who in your family has had diabetes? _____ 17. Have you ever taken cortisone (steroids)? _____

18. Have you ever taken anti-coagulants (blood thinner)?_____ 19. Do you wear contact lenses? _____

20. Do you bleed easily?_____ 21. Have you had transfusions? _____

22. Do you have any disease, condition or problem not listed? _____

FOR WOMEN ONLY

23. Are you taking oral contraceptives (birth control pills)? _____

24. Are you pregnant at the present time? _____ 25. Have you reached menopause (Change of life)? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform Doctor Stringer at my next appointment without fail.

Date_____Signature of patient _____