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## GENERAL HEALTH CHART

NAME _____ SEX M ❑ F ❑ DATE OF EXAM _____

DATE OF BIRTH _____ AGE_____ HEIGHT _____ WEIGHT _____ MARITAL STATUS - ❑ S ❑ M ❑ W ❑ D

OCCUPATION/EMPLOYER _____

### PRESENT HEALTH

1. How would you describe your present health? _____
2. Are you now under the care of a physician? Yes No
   If so, what condition is being treated? _____
3. Name and address of your physician: _____ Phone: _____
   Date of last physical exam: _____
4. What medications (pills, patches, inhalers, etc) are you presently taking including non-prescription drugs and vitamins?
   _____
5. Are you vaccinated by the Covid-19 vaccine? ❑ Yes ❑ No Vaccine (i.e. Pfizer, Moderna, J&J)_____Full vaccination date_____

### PAST MEDICAL HISTORY

6. Have you had any serious illness or operation or been hospitalized within the last five years? Yes No
   If so, what and when? _____
7. Have you ever had any allergies? Yes No
   If so, what and when? _____

### CARDIOVASCULAR

8. ❑ Have you ever had any heart trouble? Yes No
   ❑ heart attack? ❑ angina? ❑ coronary insufficiency? ❑ coronary occlusion? ❑ murmurs?
9. ❑ Has your blood pressure ever been too high? ❑ too low? Yes No
10. ❑ Have you ever had rheumatic fever? ❑ rheumatic heart disease? ❑ damaged heart valves? Yes No
11. ❑ Do you have a heart murmur? ❑ mitral valve prolapse? Yes No
12. Do you have chest pain upon exertion? Yes No
13. Are you short of breath after mild exercise or when lying down? Yes No
14. Do your ankles swell? Yes No
15. Do you have a cardiac pacemaker? Yes No
16. Do you have any inborn heart defects? Yes No
17. **Do you need to be pre-medicated before dental care?** **Yes No**
18. ❑ Are you subject to fainting spells? ❑ dizziness? ❑ chest pains? Yes No
19. Have you ever had a stroke? Yes No

### BLOOD

20. Have you ever had abnormal bleeding problems after a cut or tooth extraction? Yes No
21. ❑ Do you bruise easily? ❑ bleed easily? Yes No
22. Have you ever had severe or spontaneous nose bleeds? Yes No
23. Do you have AIDS (HIV infection)? Yes No
24. Do you have any systemic blood infections? Yes No

### ENDOCRINE

25. Do you or any member of your family have diabetes? Yes No
    If so, who? _____ What type?_____
26. Are you frequently thirsty? Yes No
27. Have you ever received treatment for any endocrine or glandular disorder? Yes No
    If so, what? _____
28. Do you have arthritis? ❑ rheumatoid? ❑ osteoarthritis? Yes No

### NERVOUS

29. Do you suffer from frequent or severe headaches? Yes No
30. Have you ever had severe pains of head or face? Yes No
31. Do you consider yourself excessively nervous? Yes No
32. Have you ever had epilepsy or convulsions? Yes No
33. Have you ever had a nervous breakdown? Yes No
34. Do you suffer from depression? Yes No
    If so, are you seeking treatment? Yes No

### RESPIRATORY

35. Do you ever become short of breath? Yes No
36. Do you have frequent colds? Yes No
37. Do you suffer from chronic sinusitis or frequent sinus infections? Yes No
38. Do you have asthma? Yes No
39. Have you had tuberculosis or a persistent cough? Yes No
40. Do you smoke? If yes, what and how much? _____ Yes No

**Please Complete Both Sides**

## G.I. and G.U.

41. Have you ever had yellow jaundice or hepatitis? Yes No
42. Have you ever had any liver or gall bladder problems? Yes No
43. Are you on any special diet? Yes No
44. Have you ever had any gastrointestinal disorder? Yes No
45. Have you had any kidney or bladder difficulty? Yes No
46. Have you ever had syphilis, herpes, gonorrhea or any other sexually transmitted disease? Yes No
    If so, what? _____

## OTHER

47. Have you ever been treated for any skin disease? _____ Yes No
48. Have you ever received x-ray or radioactive isotope treatment? _____ Yes No
49. ❑ Have you ever had local anesthesia? ❑ general anesthesia? Yes No
50. Do you have any impairment or disorder of your eyes, ears, nose or throat? _____ Yes No
51. Are you allergic to or have you had a reaction to Yes No
    local anesthetics? _____ penicillin or antibiotics? _____
    barbiturates, sedatives, sleeping pills? _____ Aspirin or NSAID's (eg. Advil)? _____
    Others: _____
52. Have you ever had a tumor or cancer? Yes No
    If so, what? _____
53. Do you have any prosthetic replacement joints? Yes No
53a. Have you ever taken or are you currently taking bisphosphonates? Yes No

## FEMALES

54. Are you now pregnant or are you anticipating pregnancy within the next year? Yes No
55. Have you undergone, or are you presently undergoing menopause? Yes No
56. Are you taking birth control medication? Yes No

## PRESENT DENTAL HEALTH

1. What is your chief dental complaint or concern? _____
2. Name of your dentist: _____ Phone _____
3. How long have you been a patient of your current dentist? _____
    Date of Last Visit: _____ Date of Last Cleaning: _____
4. How many times a year do you get your teeth cleaned? _____
5. What oral hygiene aids do you use? _____
6. Do your gums bleed? Yes No
    If so, when? _____
7. ❑ Do you feel you have bad breath? ❑ bad taste? Yes No
8. Does your jaw ever click or cause pain on opening or closing? Yes No
9. Have you noticed any shift in your teeth or bite? Yes No
10. Do you have trouble chewing? Yes No
11. Do you wake up with a sore jaw? Yes No
12. ❑ Do you ever have pain in your jaw? ❑ in your ear? If so, when? _____ Yes No
13. ❑ Have you ever noticed yourself clenching your teeth? ❑ grinding your teeth? Yes No
    If so, when? _____
14. Do you have any sensitivity to (❑ cold, ❑ hot, ❑ sweets, ❑ food)? Yes No
    If so, locate _____
15. What do you consider most important?
    ❑ preservation of natural teeth ❑ eradication of infection ❑ esthetics
    ❑ elimination of pain ❑ avoidance of removable dentures ❑ function
    other _____
16. Are the cosmetics of your smile important to you? Yes No
17. Do you feel your teeth are white enough? Yes No
18. Is there anything about your smile you want to change? If so, what? _____
19. Do you feel you have enough teeth to chew with? Yes No
    If not, would you like to have more teeth? Yes No

## PAST DENTAL HISTORY

21. Have you ever had an acute sore mouth or gum boils? Yes No
22. Did you ever wear braces for straightening your teeth? Yes No
23. Have you ever had previous periodontal or gum treatments? Yes No
    If so, when? _____ Where? _____
24. Have you ever had any serious problems associated with previous dental treatment? Yes No
    If so, explain _____
25. Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No
    If so, please explain _____

I testify that the above is an accurate representation of my medical condition.

Signature _____ Date _____