Yes No Do you have any disease, condition or problem not listed here?
Describe: _____

Yes No Have You ever been hospitalized or had surgery?
Describe: _____

Yes No Do you have any undiagnosed symptoms?
Describe: _____

Yes No Are you, or have you ever been addicted to any chemical substance?
(examples: alcohol, prescription drugs, heoin, meth, cocaine)

Yes No Do you smoke or use tobacco products?

Yes No Are you a past user of tobacco products?

Yes No Do you regularly take herbal medicines or dietary supplements?
Specifically, do you take (circle all that apply)
Echinacea Garlir Ginger Kava Valerian Feverfew Gingko Gingeng
St. John's Wort Vitamin E Other: _____

Yes No Have you undergone current or past osteoporosis therapy?
(examples are: Fosamax, Actonel, Boniva in pill form)

Yes No Have you undergone current or past therapy to reduce high blood calcium (bisphosphonate therapy)? (examples: intravenous Aredia, Zometa)

Physician List (please list your family physician and Medical specialists you see at least once a year):

Name	Address	Phone#	Specialty

Dental History

Chief Complaint (why are you seeking dental care?):_____

Yes No Do you have regular dental check ups? Date of last Check up:_____

Yes No Have you had any trouble associated with previous dental treatment?
If so, please explain: _____

Yes No Have you noticed any lumps or sores in or near your mouth?

Yes No Do your gums bleed when brushing or flossing?

Yes No Have you ever injured your face, jaw or teeth?

Yes No Do you suffer from pain in the mouth, face, eyes, neck or throat?

Yes No Are you unhappy with the appearance of your teeth?

Yes No Has fear ever prevented you from seeking dental treatment?

Circle the types of dental treatment you have had:
Orthodontics(braces) Dentures Root Canal Implants
Oral Surgery Bleaching Crowns TMJ Treatment Fillings
Periodontal(gum) Treatment Bridges Veneers Other: _____

_____ _____

Signature of Patient, Parent or Guardian **Date Signed**