Do you wear dentures or partials?_____
Do you usually have many cavities?_____
Do you lose or break fillings?_____
Do you gag easily?_____
Are you familiar with the term "Preventive Dentistry"?_____
Do you like your smile?_____
Do you want to keep your remaining teeth?_____

MEDICAL HISTORY

General Health: Excellent_____**Good**_____**Fair**_____**Poor**_____
Name, address & phone of your physician:_____
_____
Last complete physical:_____
Are you under a physicians's care now?_____**why**_____
Have you ever been treated for the following:

	Yes	No		Yes	No
Heart Trouble/Disease	_____	_____	Allergies	_____	_____
Abnormal Blood Pressure	_____	_____	Ulcers	_____	_____
Tuberculosis	_____	_____	Asthma	_____	_____
Diabetes	_____	_____	Sinus Trouble	_____	_____
Epilepsy or Seizures	_____	_____	Frequent Cough	_____	_____
Anemia	_____	_____	Hepatitis	_____	_____
Congenital Heart Lesion	_____	_____	Arthritis/Gout	_____	_____
HIV Positive	_____	_____	Stroke	_____	_____
AIDS	_____	_____	Glaucoma	_____	_____
Artificial Heart Valve	_____	_____	Artificial Joint	_____	_____
Heart Pace Maker	_____	_____	Smoke or Chew	_____	_____
Excessive or Prolonged Bleeding	_____	_____	Radiation	_____	_____
			Psychiatric Care	_____	_____
Fainting or Dizziness	_____	_____	Excessive Urination or Thirst	_____	_____
Hormone Therapy	_____	_____			
Yellow Jaundice	_____	_____			

Are you taking any medication now? Yes___**No**___
List:_____
_____

Are you allergic to any medications?_____**List:**_____

Additional information you feel important:_____

Patient signature_____