# GENERAL HEALTH HISTORY

*The following information is important for your maximum safety, comfort and optimum dental care.*
*This information will be held in utmost confidence by this office.*

1. Are you in good health? _____ Date of last physical exam: _____
2. Are you under a physician's care now? _____ If so, please give reason for treatment: _____
3. Are you taking any medication now? _____ If so, what? _____
4. Physician's name: _____ Address: _____ Phone: _____
5. Do you have or have you had any of the following diseases or problems? ☐ Heart Trouble ☐ Heart Murmur ☐ Rheumatic Fever
   ☐ High Blood Pressure ☐ Diabetes ☐ Hepatitis ☐ Tuberculosis ☐ HIV+ ☐ Epilepsy ☐ Kidney or Liver Trouble
   ☐ Blood Transfusion ☐ Allergies ☐ Asthma ☐ Anemia ☐ Other _____
6. Do you have shortness of breath, pains in the chest or swollen joints? _____
7. Are you subject to any nervous disorders, dizzy spells or fainting? _____
8. Have you ever had any trouble with prolonged bleeding? _____
9. Have you ever had unusual reactions to any anesthetic or drug? _____
10. Has a dentist or physician warned you against taking any specific medicine? _____
11. Has a physician ever placed you on a special diet? _____
12. Are you pregnant? _____ How many months? _____
13. Approximate date of last full mouth x-rays (14-16 films): _____
14. Do you have any present complaints? _____
15. Are your teeth sensitive to cold, heat or sweets? _____
16. Is there anything you would like to change about the appearance of your teeth or smile? _____
17. Do you have any spaces between your teeth that you don't like? _____
18. Are you satisfied with the color of your teeth? _____
19. Do you chew on only one side of your mouth? _____ If so, why? _____
20. Do you habitually clench you teeth during the night or day? _____
21. Do you have popping or clicking in your jaw? _____
22. Do you play sports? _____ Which one(s)? _____
23. Do you wear a mouth guard while playing sports? _____
24. Do you feel sleepy or tired during the day? _____
25. Do you snore at night or have sleep apnea? _____
26. Any other information you feel we should know about your health: _____ About dental visits: _____

    Explain: _____

NAME OF FRIEND/RELATIVE (in area, not living with you) _____ PHONE (  ) _____

IN CASE OF EMERGENCY, CONTACT: NAME _____ PHONE (  ) _____

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient.
I also agree to assume full financial responsibility for all treatment rendered.

SIGNATURE _____ DATE _____