Patient Name _____ DOB _____

For the following questions, circle YES or NO, whichever applies. Your answers are for our records only, and will be confidential.
THESE FACTS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH

Sex:_____ Height:_____ Weight: _____ Age: _____ Race: _____ Date Date

Your Medical History

__/__/__ __/__/__

1. Are you in good general health?	YES / NO	YES / NO	YES / NO	YES / NO
2. Has there been any change in your health in the past year?	YES / NO	YES / NO	YES / NO	YES / NO
3. Approximately when was your last Physical Examination?	___/__/___	___/__/___	___/__/___	___/__/___
4. Are you PRESENTLY under a physician's care?	YES / NO	YES / NO	YES / NO	YES / NO
If YES, for what condition(s)? _____				
5. The phyisician's name..... _____				
address ..... _____				
_____				
phone number..... _____				
6. Have you had any serious illness or operation?	YES / NO	YES / NO	YES / NO	YES / NO
If YES, please list: _____				
7. Have you been hospitalized or had a serious illness within the past 5 years?	YES / NO	YES / NO	YES / NO	YES / NO
If YES, explain: _____				

Your cardiovascular system

CV1. Do you have or have you ever had any of the following (please circle):	YES / NO	YES / NO	YES / NO	YES / NO
Heart trouble Heart attack Coronary insufficiency				
Stroke Damaged heart valves Congenital heart disease				
CV2. Rheumatic heart disease, heart murmur?	YES / NO	YES / NO	YES / NO	YES / NO
CV3. Chest pain after exertion?	YES / NO	YES / NO	YES / NO	YES / NO
CV4. Shortness of breath after exercise?	YES / NO	YES / NO	YES / NO	YES / NO
CV5. Do your ankles swell? .	YES / NO	YES / NO	YES / NO	YES / NO
CV5. Do you need extra pillows to sleep?	YES / NO	YES / NO	YES / NO	YES / NO
CV7. Do you have a cardiac pacemaker?	YES / NO	YES / NO	YES / NO	YES / NO
CV8. Do you have any blood pressure problems?	YES / NO	YES / NO	YES / NO	YES / NO
If YES, ...	HIGH/LOW	HIGH/LOW	HIGH/LOW	HIGH/LOW

Your central nervous system

CN1. Do you have or have you ever had:				
CN1A. Epilepsy?	YES / NO	YES / NO	YES / NO	YES / NO
CN1B. Fainting spells?	YES / NO	YES / NO	YES / NO	YES / NO
CN1C. Seizures?	YES / NO	YES / NO	YES / NO	YES / NO
CN1D. Emotional Disturbances?	YES / NO	YES / NO	YES / NO	YES / NO
CN2. Do you follow any treatment for a nervous disease?	YES / NO	YES / NO	YES / NO	YES / NO

Your respiratory system

RE1. Do you have a persistent cough?	YES / NO	YES / NO	YES / NO	YES / NO
RE2. Do you have or have you ever had tuberculosis?	YES / NO	YES / NO	YES / NO	YES / NO
RE3. Is there any history of tuberculosis in your family?	YES / NO	YES / NO	YES / NO	YES / NO
RE4. Do you have any sinusitis, sinus trouble?	YES / NO	YES / NO	YES / NO	YES / NO
RE5. Do you have emphysema, chronic bronchitis, asthma?	YES / NO	YES / NO	YES / NO	YES / NO

Your digestive system

G11. Do you have ANY stomach ulcers?	YES / NO	YES / NO	YES / NO	YES / NO
G12. Do you have or have you ever had:				
G12A. Hepatitis?	YES / NO	YES / NO	YES / NO	YES / NO
G12B. Jaundice?	YES / NO	YES / NO	YES / NO	YES / NO

G12C. Liver disease? ...	YES / NO	YES / NO	YES / NO	YES / NO
G13. Have you ever vomited blood?	YES / NO	YES / NO	YES / NO	YES / NO
G14. Do you have ANY diarrhea?	YES / NO	YES / NO	YES / NO	YES / NO

Your endocrine system

EN1. Do you have diabetes?	YES / NO	YES / NO	YES / NO	YES / NO
EN2. Does anyone in your family have diabetes?	YES / NO	YES / NO	YES / NO	YES / NO
EN3. Do you urinate more than six times a day?	YES / NO	YES / NO	YES / NO	YES / NO
EN4. Are thirsty very often or do you have a dry mouth?	YES / NO	YES / NO	YES / NO	YES / NO
EN5. Do you have hypothyroidism or hyperthyroidism?	YES / NO	YES / NO	YES / NO	YES / NO

Your hematopoietic system

HB1. Do you have anemia, Sickle Cell disease, blood disorder?	YES / NO	YES / NO	YES / NO	YES / NO
HB2. Is there ANY family history of blood disorders?	YES / NO	YES / NO	YES / NO	YES / NO
HB3. Are you hemophilic? ..	YES / NO	YES / NO	YES / NO	YES / NO
HB4. Have you had abnormal bleeding after any surgery, extraction, or trauma?	YES / NO	YES / NO	YES / NO	YES / NO
HB5. Have you ever had a blood transfusion?	YES / NO	YES /NO	YES / NO	YES / NO
HB6. Immunodificency problems?	YES / NO	YES / NO	YES / NO	YES / NO

Your allergies

AL1. Are you allergic to or have you acted adversely to:				
AL1A. Local anesthetics?	YES / NO	YES / NO	YES / NO	YES / NO
AL1B. Antibiotics, Penicillin, Sulfa Drugs?	YES / NO	YES / NO	YES / NO	YES / NO
AL1C. Barbituates, sedatives, or sleeping pills?	YES / NO	YES / NO	YES / NO	YES / NO
AL1D. Aspirin?	YES / NO	YES / NO	YES / NO	YES / NO
AL1E. Iodine?	YES / NO	YES / NO	YES / NO	YES / NO
AL1F. Codeine or other narcotics?	YES / NO	YES / NO	YES / NO	YES / NO
AL1G. Others, please specify: _____				
AL2. Do you have asthma or hay fever?	YES / NO	YES / NO	YES / NO	YES / NO
AL3. Do you have or have you ever had hives or skin rash?	YES / NO	YES / NO	YES / NO	YES / NO

Your genitourinary system

UR1. Do you have or have you ever had:				
UR1A. Kidney trouble?	YES / NO	YES / NO	YES / NO	YES / NO
UR1B. Syphilis, gonorrhea?	YES / NO	YES / NO	YES / NO	YES / NO

Your bones and joints

B11. Do you have:				
BJ1A. Arthritis?	YES / NO	YES / NO	YES / NO	YES / NO
BJ1B. Inflammatory rheumatism?	YES / NO	YES / NO	YES / NO	YES / NO
BJ1C. Bone infection? ...	YES / NO	YES / NO	YES / NO	YES / NO
BJ1D. Osteoporosis?	YES / NO	YES / NO	YES / NO	YES / NO

Your neoplasma

TR1. Do you have or have you ever had:				
TR1A. Tumor or malignancy?	YES / NO	YES / NO	YES / NO	YES / NO
TR1B. Chemotherapy, or radiation therapy?	YES / NO	YES / NO	YES / NO	YES / NO
Do you have or have you ever had ANY disease, condition or promlem NOT				
listed above that you think we should know about	YES / NO	YES / NO	YES / NO	YES / NO
If so, please explain: _____				
Are you regularly exposed to x-rays or ANY other ionizing radiation				
or toxic substances?	YES / NO	YES / NO	YES / NO	YES / NO
Do you have glaucoma?	YES / NO	YES / NO	YES / NO	YES / NO
If so,	WIDE/CLOSED	WIDE/CLOSED	WIDE/CLOSED	WIDE/CLOSED

Are you wearing or do you wear, contact lenses?	YES / NO	YES / NO	YES / NO	YES / NO
Do you drink alcohol?	YES / NO	YES / NO	YES / NO	YES / NO
If so, how much and how often? _____				
Do you smoke tobacco?	YES / NO	YES / NO	YES / NO	YES / NO
Do you use oral tobacco?	YES / NO	YES / NO	YES / NO	YES / NO
If so, how much and how often? _____				

Your medications

ME1. Are you taking any of the following medications:

ME1A. Antibiotics, or Sulfa Drugs?	YES / NO	YES / NO	YES / NO	YES / NO
ME1B. Anticoagulants, blood thinning agents?	YES / NO	YES / NO	YES / NO	YES / NO
ME1C. Medicine for high blood pressure?	YES / NO	YES / NO	YES / NO	YES / NO
ME1D. Tranquilizers?	YES / NO	YES / NO	YES / NO	YES / NO
ME1E. Iodine?	YES / NO	YES / NO	YES / NO	YES / NO
ME1F. Codeine or other narcotics?	YES / NO	YES / NO	YES / NO	YES / NO
ME1G. Other? Please list _____				
_____				

For women

Are you pregnant?	YES / NO	YES / NO	YES / NO	YES / NO
Are you nursing?	YES / NO	YES / NO	YES / NO	YES / NO
Do you have any problems associated with your menstrual period?	YES / NO	YES / NO	YES / NO	YES / NO
Are you taking oral contraceptives or hormonal therapy?	YES / NO	YES / NO	YES / NO	YES / NO

Your dental history

What is your chief dental complaint? _____

Are you experiencing any discomcort or pain at this time?	YES / NO	YES / NO	YES / NO	YES / NO
Are you satisfied with the appearance of your teeth?	YES / NO	YES / NO	YES / NO	YES / NO
Are you able to eat and chew foods satisfactorily?	YES / NO	YES / NO	YES / NO	YES / NO
Do you have headache, ear aches, or neck pain?	YES / NO	YES / NO	YES / NO	YES / NO
Do you frequently experience sinus problems?	YES / NO	YES / NO	YES / NO	YES / NO
Have you had ANY serious trouble associated with ANY previous dental treatment? .	YES / NO	YES / NO	YES / NO	YES / NO

If YES, please explain _____

Other conditions not listed

_____

_____

_____

General dental responsibility and consent statement

I hereby authorize and request the performance of dental services for myself or for:

_____ _____

I also give consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or his supervised stuff for diagnostic purposes or dental treatment. There records may include study models, photographs, x-rays, and blood studies. I understand that these records are property of Eric Meeker, DDS, PA I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment and its fee modification. I understand and acknowledge that I am financially responsible for the services provided for myself an the above named, regardless of insurance coverage.

To the best of my knowledge the information provided in this form is accurate and complete.

_____ _____

Signature of patient, parent, or guardian Date