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General Health Chart

Name_______________ Date of Exam_______________ Date of Birth_______________

Height_______________ Weight _______________ Marital status_______________

Since the cause of dental disease is a combination of many factors, and is very complex, it is necessary to investigate any possible contributing influences. The success of treatment depends upon the control of all causative factors.

Although many of these questions may not directly involve your dental condition, they are all related to the successful management of your case.

Please answer all the questions to the best of your ability. Your responses are for our records only and will be kept confidential.

PRESENT HEALTH:

1. How would you describe your present health?_______________

2. Are you now under the care of a physician? . . . . . . ❏ Yes ❏ No

3. Name and address of your physician._______________

a. Phone:_______________

b. Date of your last physical exam._______________

c. What medications are you presently taking?_______________

PAST MEDICAL HISTORY:

5. Have you had any serious illness or operation? . . . . . . ❏ Yes ❏ No

a. If so, what and when?_______________

6. Have you ever had any allergies? . . . . . . ❏ Yes ❏ No

a. If so, What and when?_______________

CARDIOVASCULAR:

7. Have you ever had any heart trouble? . . . . . . ❏ Yes ❏ No

Murmurs? . . . . . . ❏ Yes ❏ No

8. Has your blood pressure ever been too high? . . . . . . ❏ Yes ❏ No

a. Too low? . . . . . . ❏ Yes ❏ No

9. Have you ever had rheumatic fever? . . . . . . ❏ Yes ❏ No

a. Rheumatic heart disease? . . . . . . ❏ Yes ❏ No

10. Are you a subject to fainting spells? . . . . . . ❏ Yes ❏ No

a. Dizziness? . . . . . . ❏ Yes ❏ No

b. Chest pains? . . . . . . ❏ Yes ❏ No

11. Have you ever had a stroke? ❑ Yes ❑ No

BLOOD:

12. Have you ever had abnormal bleeding after a cut or tooth extraction? ❑ Yes ❑ No

13. Do you bruise easily? ❑ Yes ❑ No

a. Bleed easily? ❑ Yes ❑ No

14. Have you ever had severer spontaneous nose bleeds? ❑ Yes ❑ No

ENDOCRINE:

15. Do you or any member of your family have diabetes? ❑ Yes ❑ No

16. Have you ever received treatment for any endocrine or glandular disorder? ❑ Yes ❑ No

NERVOUS:

17. Do you suffer frequent or severe headaches? ❑ Yes ❑ No

18. Heave you ever had sever pains of head or face? ❑ Yes ❑ No

19. Do you consider yourself excessively nervous? ❑ Yes ❑ No

20. Have you ever had epilepsy or convulsions? ❑ Yes ❑ No

21. Have you ever had a nervous brake down? ❑ Yes ❑ No

RESPIRATORY:

22. Do you ever become short of breath? ❑ Yes ❑ No

23. Do you have frequent colds? ❑ Yes ❑ No

24. Do you have asthma? ❑ Yes ❑ No

25. Have you had tuberculosis or a persistent cough? ❑ Yes ❑ No

26. Do you smoke? ❑ Yes ❑ No

a. If so, what and how much?______________________________

G.I. AND G.U.

27. Have you ever had yellow jaundice, hepatitis or AIDS? ❑ Yes ❑ No

28. Have you ever had any liver or gall bladder problems? ❑ Yes ❑ No

29. Are you on any special diet? ❑ Yes ❑ No

30. Have you ever had any gastrointestinal disorder? ❑ Yes ❑ No

31. Have you any kidney or bladder difficulty? ❑ Yes ❑ No

32. Have you ever had syphilis or gonorrhea? ❑ Yes ❑ No

OTHER:

33. Are you sensitive to aspirin, penicillin, novocain, codeine or any other drug? ❑ Yes ❑ No

34. Have you ever been treated for any skin disease? . . . . ❏ Yes ❏ No

35. Have you ever received radiation or radioactive isotope treatment? . . . . ❏ Yes ❏ No

36. Have you ever had a tumor or cancer? . . . . ❏ Yes ❏ No

37. Have you ever had a local anesthesia? . . . . ❏ Yes ❏ No

a. General anesthesia? . . . . ❏ Yes ❏ No

38. Do you have arthritis? . . . . ❏ Yes ❏ No

39. Do you have any impairment or disorder of your eyes, ears, nose, or throat? . . . . ❏ Yes ❏ No

FEMALES:

40. Are you now pregnant or are you anticipating pregnancy within the next year? . . . . ❏ Yes ❏ No

41. Have you undergone, or are you presently undergoing menopause? . . . . ❏ Yes ❏ No

42. Are you taking birth control medication? . . . . ❏ Yes ❏ No

PRESENT DENTAL HEALTH:

1. Date of last visit to dentist.____

a. What treatment was rendered during this last visit?____________________________

b. Reason for today's visit.____

2. Do your gums bleed? . . . . ❏ Yes ❏ No

a. If so, when?____

3. Are you aware of a bad taste or odor in your mouth? . . . . ❏ Yes ❏ No

4. Does your jaw ever click or cause pain on opening or closing?. . . . . ❏ Yes ❏ No

5. Do you have trouble chewing? . . . . ❏ Yes ❏ No

6. Have you noticed any shift in your teeth or bite? . . . . ❏ Yes ❏ No

7. Do you ever have pain in your jaw? . . . . ❏ Yes ❏ No

a. In your ear? . . . . ❏ Yes ❏ No

8. Have you ever noticed yourself clenching your teeth or bite? . . . . ❏ Yes ❏ No

a. Grinding your teeth? . . . . ❏ Yes ❏ No

b. If so, when?____

9. Is any area of your mouth sore to pressures or irritants (cold, hot, sweets, food)? . . . . ❏ Yes ❏ No

a. If so, locate.____

10. When were you last check - up X-rays taken?____

11. When were your last full mouth X-rays taken?____

12. When did you last have your teeth cleaned?____

a. Where?____

13. What oral hygiene aids do you use?____

a. How often?____

14. What do you consider most important? ____________________________________

Preservation of natural teeth | Irradication of infection | Esthetics

Avoidance of removable dentures | Elimination of pain | Function

Other____

15. Is there any concern about the cosmetic appearance of your teeth? . . . . Yes No

PAST DENTAL HISTORY:

16. Have you ever had an acute sore mouth or gum boils? . . . . Yes No

17. Did you ever wear braces for straightening your teeth? . . . . Yes No

18. Have you ever been instructed in care of your gums or prevention of decay? . . . . Yes No

19. Have you ever had previous periodontal or gum treatments? . . . . Yes No

a. If so, When?____

b. Where?____

20. Have you ever had a tooth removed? . . . . Yes No

a. If so, when?____

21. Have you ever had any serious problems associated with previous dental treatment? . . . . Yes No

a. If so, explain____

22. Do you have any disease, condition, or problem not listed above that you think I should know about?.. Yes No

a. If so, please explain____

Patient's Signature____