



	Yes	No	I Don't Know
Circulatory Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal or Excessive Bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or Painful/Swollen Joints.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/ Hay fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes or Family History of Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Jaundice, Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems/ Hyperacidity .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV or AIDS .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any form of Herpes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble/ Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems/ Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Cough or Cough that Produces Blood .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Swollen Glands.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throats .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/ Migraine .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells/ Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Diarrhea or recent weight loss.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measles/Mumps/ Scarlet Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/ Tumors .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Therapy/ Chemotherapy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**DENTAL HISTORY**

What is your main complaint? \_\_\_\_\_

When was your last dental examination? \_\_\_\_\_

Are you dissatisfied with the appearance of your teeth? \_\_\_\_\_

Do you have any of the following?

	Yes	No	I Don't Know
Dental Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot and cold Sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty chewing .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pop and Click in Jaw.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant Dental Experience .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear or Neck Pain .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
Signature of Patient ( Parent if Patient is Minor)

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Signature of Doctor