MEDICAL HEALTH SURVEY

Name of Medical Doctor/clinic	Date of last medical checkup

Have you had any history, difficulty with or diagnosis of any of the following?

☐ Anemia	☐ Chemical Dependency	☐ Hepatitis
☐ Anxiety	☐ Diabetes	☐ HIV/AIDS
☐ Asthma	__ diet controlled	☐ Rheumatic Fever
☐ Allergies	__ drug controlled	☐ Seizures
☐ Blood Pressure	__ insulin dependent	☐ Sexually Transmitted Diseases
___ high blood pressure	☐ Epilepsy	☐ Mental Illness
___low blood pressure	☐ Headaches	☐ Joint Replacements
☐ Cancer (date:)	☐ Heart Problems	☐ Transplant of Organ
__ radiation (date:)	☐ Heart surgery	☐ Tuberculosis
__ chemo (date:)	☐ Mitral Valve Prolapse	☐ Currently pregnant

Medical conditions not listed above:
Medications you are taking now (prescription, over-the-counter, vitamins)
Reason for medication:
Are you allergic to any medications? (antibiotics, anesthetics, pain medications, etc)

DENTAL HEALTH SURVEY

Name of previous dentist/dental clinic	City
Date of last checkup	Date of last X-rays
Are your teeth sensitive to: ( ) hot	( ) cold ( ) sweets ( ) chewing
Have you ever had any facial injuries?	
Have you ever had orthodontic treatment?	
Have you ever or do you currently wear a retainer or bite splint?	
Have you had any 3rd molars (wisdom teeth) extractions?	
What do you use to clean your teeth?	
Do you smoke or chew tobacco?	
Do you or have you ever had a piercing in your oral cavity?	
Have you used nitrous oxide with previous dental treatment?	
Do you have any medical health concerns that impact/interfere with your dental health?	
Do you currently have any dental health concerns?	
Are you happy with your appearance and condition of your teeth?	
What would you like to have done to improve your overall dental health and appearance?	
Please list any previous experience or problems you would like the dentist/hygienist to be aware of.	
Signature	Date: