

Medical History

Is the patient in good health? Y N If no, explain _____

Does the patient have any history of major illness? Y N If yes, explain _____

Check any of the following for which the patient has been diagnosed or treated:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Fainting or dizziness	<input type="checkbox"/> Transplants
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Artificial joints
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Artificial Heart valve	<input type="checkbox"/> Hepatitis type: _____	_____
<input type="checkbox"/> Bone disorders	<input type="checkbox"/> Kidney disease	_____
<input type="checkbox"/> Bleeding abnormality	<input type="checkbox"/> Learning disability	_____
<input type="checkbox"/> Blood disease	<input type="checkbox"/> Liver disease	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Nervous disorder	
<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Prolonged bleeding	
<input type="checkbox"/> Endocrine problems	<input type="checkbox"/> Rheumatic fever	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Tuberculosis	

Please list any **surgeries**/hospitalizations that the patient has had _____

Please list any **allergies** to food or medication: _____

Is the patient allergic to latex? Y N Is the patient allergic to nickel? Y N

Does the patient have trouble wearing jewelry? Y N

Please list any **medications** the patient is taking currently _____

Women Only: Are you pregnant? Y N Are you nursing? Y N

Dental History

Who is the patient's dentist? _____

When was the patient's last dental appointment? _____

Please describe any injuries to the face, mouth, or teeth the patient has had _____

Has the patient ever sucked a thumb or fingers? Y N Until what age? _____

Does the patient still suck a thumb or fingers? Y N

Does the patient breathe through his/her mouth while awake? Y N

Does the patient breathe through his/her mouth while asleep? Y N

Have you been informed that the patient has any missing or extra teeth? Y N

Signature of Patient or responsible party

Date

Dr. Mullen's comments: