1. Is this patient experiencing pain/discomfort/swelling or toothaches? (circle one)

2. Is this the first dental visit ever for this patient?

3. Is this patient under treatment by a physician?

4. Is this patient taking any medications?

5. Has this patient ever been seriously sick, hospitalized or had surgery?

6. Has a physician ever told you that this patient has a heart murmur?

7. Is this patient physically, mentally or emotionally disabled? If YES, you must complete the Supplemental Health Form.

8. Does this patient have a learning disability?

9. Has this patient ever had any history of the following? If YES, check the appropriate space. If NO, check here _______.
   - Anemia
   - Kidney or Liver disorders
   - Asthma
   - Childhood diseases (mumps, measles)
   - Bleeding disorders
   - Seizures / Epilepsy
   - Diabetes
   - Tuberculosis
   - Heart Disorders
   - Infectious Disease
   - Hepatitis
   - Other _________________________

10. Has this patient been tested for HIV/AIDS?

11. Is this patient allergic to any medication or products? (such as penicillin, artificial flavors/colors, rubber latex, other) _________________________

12. Has this patient ever had any history of the following oral habits:
   - Pacifier
   - Mouth breathing
   - Grinds Teeth
   - Other
   - Thumb / finger sucking
   - Nail Biting
   - Tobacco Use

13. Is this patient pregnant? If YES, when is the due date?

14. What is the drinking water source for this patient (check one):
   - City water _______, Name of City __________________ Do you use a water filter? _______
   - A private well _______ Bottled water _______

15. Previous significant trauma to face or jaw? If YES, describe _________________________

16. Do you anticipate this patient having difficulty accepting dental treatment?

17. Are you anxious, fearful for this visit?

18. Do you or your child’s caretaker have any untreated dental needs?

PARENT OR GUARDIAN SIGNATURE _______________________ RELATIONSHIP TO PATIENT ________________

PARENT OR GUARDIAN PRINT YOUR NAME ____________________________

FACULTY SIGNATURE ___________________________ DATE ____________