DENTAL HEALTH: Please circle one: Excellent Good Fair Poor

Reason for Today's Visit:________________________ Date of Last Dental Care:_______________

How often do you brush?_____________ Floss?____________

What are your Dental Concerns?____

MEDICAL HEALTH: Please circle one: Excellent Good Fair Poor

Physician's Name____

Date of last complete physical: _______ Are you under a doctor's care now? ______ If yes, for what reason? ________________________ Do you smoke? Yes No

How many packs per day? _____ Have you ever received a blood transfusion? Yes No

When?_________________________ Are you subject to prolonged bleeding? Yes No

Soda consumption per day: _____Candy consumption per day: _________

Women Only

May Be Pregnant? Yes No

How many Months?_____

Are you taking Hormones or Contraceptives?______

Please CHECK if you have or have had any of the following:

__Heart Trouble	__Blood Disease	__Allergies	__Cancer
__High Blood Pressure	__Anemia	__Asthma	__Prostate
__Low Blood Pressure	__Chest Pain	__Hay Fever	__Glaucoma
__Heart Murmur	__Shortness of Breath	__Sinus Trouble	__Hepatitis C
__Rheumatic Fever	__Fainting or Dizziness	__Emphysema	__Arthritis/Gout
__Congenital Heart Lesion	__Stroke	__Frequent Cough	
__Artificial Heart Valve	__Diabetes	__Lung Disease	
__Heart Pacemaker	__Artificial Joint/Hips	__Liver Disease	
__Heart Surgery	__Kidney Trouble	__Hepatitis A (infectious)	
__Mitral Valve Prolepses	__Ulcers	__Hepatitis B (serum)	
__Epilepsy or Seizures	__Alzheimer's Disease	__Hypoglycemia	
__Hemophilia	__HIV Positive	__Herpes/Cold Sores	
__Recent Weight Loss	__Psychiatric Care	__Chemotherapy/Radiation	
__Thyroid Disease	__Parathyroid Disease	__X-Ray/Cobalt Treatment	

Allergies

Circle all allergies your hild have:

Aspirin Sulfa Penicillin
Codeine Local Anesthetic
Latex Other: ___________

Medications

List Medications You Are Taking:

____

____

List Any Vitamins You Are Taking:

____

____

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Shur or any of her staff responsible for any errors of omissions that I may have made in the completion of this form.

Patient Signature: ____ Date: _______________________

Medical Update: Office use only

Date:__________ Changes in H.H.____

Date:__________ Changes in H.H.____

Date:__________ Changes in H.H.____