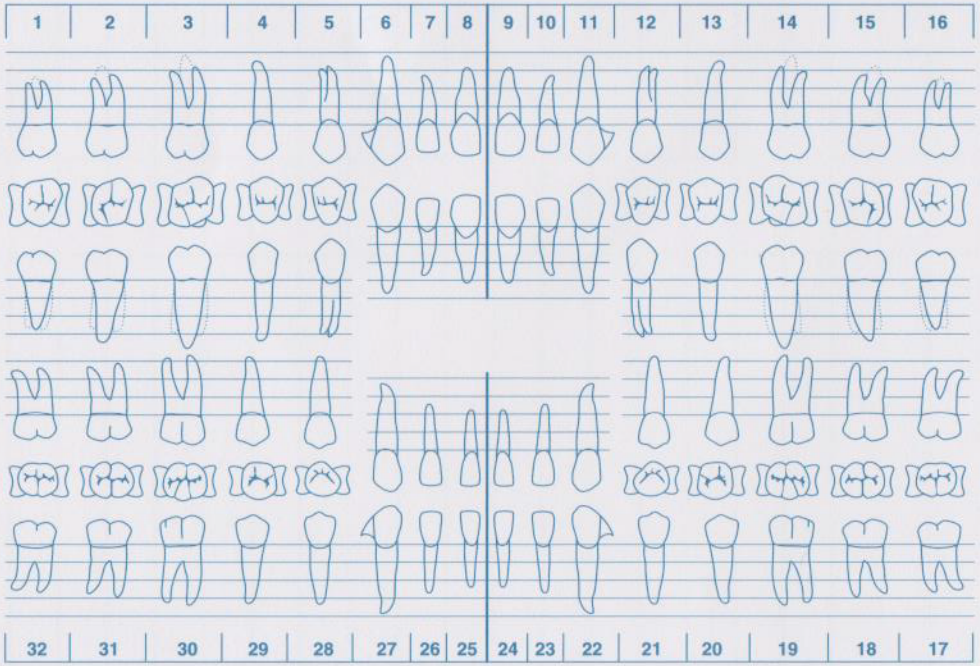
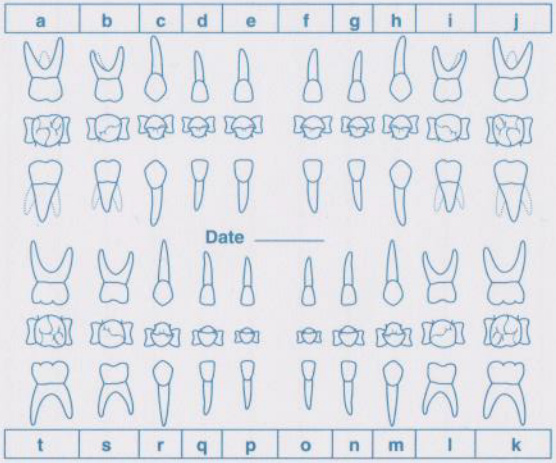
EXAMINATION RECORD

Name	Birthdate	Examination date	Medical alerts	Account number





Type X-rays
Date
Diagnostic models
Date
Photograph
Vitality test
Blood pressure:
S____ / D____ / ____
Plaque
Calculus
Abnormalities

MEDICAL HISTORY (child also see lower left)

	✓ Yes	✓ No
Are you in good health		
Are you under medical treatment		
Are you taking medicine regularly		
If so, what medicines		
Do you have or have you had:		
Heart trouble		
High or low blood pressure		
Diabetes		
Rheumatic fever		
Tuberculosis		
Asthma		
Hepatitis		
Arthritis		
Allergies		
Bleeding problems		
Have you had a reaction to:		
Penicillin (antibiotics)		
Sulfa		
Anesthetics like novocaine		
Aspirin		
Other (describe)		
Do you have any other medical condition(s) that we should be aware of		

If yes, what

DENTAL HISTORY

	✓ Yes	✓ No
Are you bothered with:		
Tender teeth when chewing		
Bleeding gums		
Bad breath		
Sore areas in your mouth		
Pain in or near your ears		
Spaces developing between teeth		
Sensitivity to heat, cold, sweets		
Have you been treated by a Periodontist		
Have you been treated by an Orthodontist		
Have you received personal instruction in the care of your teeth		
Do you wish to maintain your own teeth and avoid dentures		

If not, why not

Date last dental visit

FOR CHILD 12 OR YOUNGER PLUS MEDICAL HISTORY

	✓ Yes	✓ No
Is this the first dental visit		
Have there been unpleasant medical or dental visits		
Is there a finger sucking habit		
Check if involved with following programs:		
_____ Speech therapy _____ Special education _____ Physically handicapped		
Have there been fluoride treatments		

Signature x _____ Date _____
(Patient, Parent, Guardian)

Summary (for Doctor use)