

LAWRENCE H. SCHOONOVER, D.D.S.
P.O. Box 672 1 French St.
Clendenin, WV 25045
Phone 548-7227 965-7007

Name _____ Birthplace _____

Age _____ Sex _____ Height _____ Weight _____ Marital Status _____ Occupation _____ Race _____

Physician, address, and phone _____

Date of last physical examination _____ Reason _____ Findings _____

Are you presently being treated by a physician? _____ Reason _____

Are you presently taking any medicine, pills, drugs? _____ Reason _____

Radiation History M & D _____

Chief Complaint _____

Date _____ To the best of your knowledge, have you ever had or have you now: (Please check at left each item)

Yes	No	(Check Each Item)	Yes	No	(Check Each Item)	Yes	No	(Check Each Item)
		CARDIOVASCULAR SYSTEM			Chronic cough, hoarseness, or sore throat			BONES AND JOINTS
		Heart trouble or heart murmurs +			Tobacco, snuff, or alcohol habit			Arthritis or rheumatism
		Pain or pressure in chest			GASTROINTESTINAL SYSTEM			Frequent fractures or dislocations
		Rheumatic fever or growing pains +			Stomach or intestinal trouble			A condition requiring cortisone therapy +
		Swollen or painful joints			Frequent indigestion, diarrhea, or vomiting problems			SPECIAL ORGANS
		Soaking sweats with prolonged fever			Appetite problem or difficulty in swallowing			Ear, eye, nose or throat trouble
		High or low blood pressure +			Jaundice, hepatitis +			Sinusitis or headaches
		Shortness of breath			Liver trouble, gall bladder trouble or stones			Facial injuries or toothaches
		Frequent nose bleeds			GENITOURINARY SYSTEM			OTHERS
		Problems associated with a stroke			Kidney disease or a problem of frequent urination			Tumors, growths, cysts or cancers +
		ENDOCRINE SYSTEM			Swollen ankles or eye lids			Recent gain or loss of weight
		Gland problem, goiter, or thyroid condition			NERVOUS SYSTEM			Scarlet fever, pneumonia, mumps, or any high fever disease
		Diabetes (sugar or albumin in urine) +			Nervous or mental disorders			A reaction to serums, drugs or medicines +
		Dry or burning mouth			Epilepsy or convulsions +			Any reaction to penicillin, antibiotics or dental anesthetics +
		Members of your family with diabetes or tuberculosis +			Neuritis, neuralgia or numbness			Series of needles, shots or injections
		RESPIRATORY SYSTEM			BLOOD			Major operations or hospitalization
		Respiratory disease			Blood diseases			Pregnancy or menstrual problems
		Continuous stuffy nose			Dizziness or fainting spells Anemia			Skin rash, hives, or other skin problems
		Asthma, hayfever, or allergies +			Bleeding gums			Veneral disease or any other conditions we should be aware of +
		Tuberculosis A halitosis problem			Excess bleeding following a scratch, cut or tooth extraction +			AIDS Risk +

MEDICAL CONSULTATION

NAMES OF FAMILY MEMBERS

LAWRENCE H. SCHOONOVER, D.D.S.
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DATE:

DISCUSSION:

DENTAL HISTORY: (Investigate the following items)

Comments:

1. Regularity of dental visits
2. Regularity of oral prophylaxis
3. Previous gum treatment
4. Previous orthodontic treatment
5. Previous extractions
6. Previous root canal therapy
7. Reasons for teeth loss
8. Dental appliances worn by patient
9. Oral habits
10. Hereditary dental factors
11. Dietary aspects of oral health
12. Unusual dental experience

Completed by: _____