

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

Primary reason for this dental appointment  Examination  Emergency  Consultation

### Dental History

Please Circle

Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No
Do you have dental examinations on a routine basis? Last visit \_\_\_\_\_ Yes No
Do you think you have active decay or gum disease? \_\_\_\_\_ Yes No
Do you brush and floss on a routine basis? Discuss \_\_\_\_\_ Yes No
Do your gums ever bleed? Discuss \_\_\_\_\_ Yes No
Do you like your smile? Why? \_\_\_\_\_ Yes No
Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No
Do you want to keep your remaining teeth? \_\_\_\_\_ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_ Yes No
Have your past experiences in a dental office always been positive? \_\_\_\_\_ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss \_\_\_\_\_ Yes No
Name of previous dentist (optional): \_\_\_\_\_
Date of last full mouth x-rays (16 small films or panoramic): \_\_\_\_\_

### Medical History

Are you under a physician's care now? Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone \_\_\_\_\_ Yes No
Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No
Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? \_\_\_\_\_ Yes No
Are you on a special diet? Discuss \_\_\_\_\_ Yes No
Are you allergic to any medications or substances? Please check box below \_\_\_\_\_ Yes No
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex Rubber [ ] Milk [ ] Other \_\_\_\_\_ Yes No
Women (Please check): [ ] Pregnant/trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives Discuss \_\_\_\_\_ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.

\*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

Table with 10 columns of medical conditions and checkboxes for Yes/No. Conditions include Heart Disease/Surgery, Excessive Bleeding, Chemotherapy, Night Sweats, Cold Sores, Heart Murmur or Defect\*, Sickle Cell Disease, Osteoporosis, Yellow Jaundice, Fever Blisters, Irregular Heart Beat, Hemophilia, Bisphosphonates, Kidney Problems, Herpes, Heart Attack/Failure, Leukemia, Aredia I.V. Reclast I.V., Thyroid Disease, Convulsions, Congenital Heart Disorder\*, Recent Blood Transfusion, Iometa I.V., Parathyroid Disease, Epilepsy or Seizures, Mitral Valve Prolapse, Swelling of Limbs, Fosamax, Actonel, Boniva, Arthritis/Gout, Fainting or Dizziness, Scarlet Fever, Lung Disease, Stomach/Intestinal Disease, Rheumatism, Glaucoma, Heart Pace Maker\*, Frequent Cough, Rheumatic Fever\*, Breathing Problem, Ulcers, Pain in Jaw Joints, Tumors or Growths, Artificial Heart Valve\*, Shortness of Breath, Recent Weight Loss, Cortisone Medicine, Nervousness, Alzheimer's Disease, Allergies (Medicines), Allergies (Pollen I Dust), Pulmonary Shunt\*, Hay Fever, Frequent Diarrhea, Artificial Joint\*, Psychiatric Care, High Blood Pressure, Sinus Trouble, Diabetes, Sexually Transmitted Disease, Low Blood Pressure, Asthma, Excessive Thirst, AIDS, Bacterial Endocarditis\*, Bloody Sputum, Hypoglycemia, HIV Positive, Need Premedication?, Ever taken fen-phen?\*, Cochlear implants?, Hepatitis A (Infectious), Hepatitis B or C, Tattoos/Body Piercing, Protease Inhibitor, Sleep Apnea, Unexplained Fever, Emphysema, Liver Disease, Genital Herpes, Hives or Rash, Bruise Easily/Blood Disease, Tuberculosis, Anemia, Cancer, Coronary Stent\*, X-Ray Treatments (Radiation), Drug Addiction/Alcoholism.

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No

Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X \_\_\_\_\_ Date \_\_\_\_\_
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_

History Review and Significant Findings \_\_\_\_\_

### Medical Updates

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

Table with 4 columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, PULSE, REVIEWED BY. Includes rows for None [ ] and Dr. \_\_\_\_\_

