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.

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

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.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____

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Dental and medical histories