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? _____	Yes	No
Does food catch between your teeth? Any loose teeth? _____	Yes	No
Have your past experiences in a dental office always been positive? _____	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you grind? _____	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? _____	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 on a special diet or have you ever taken Fen-Phen? Discuss _____	Yes	No
Are you taking any medications, pills, or drugs? Please list _____	Yes	No
_____		
Are you allergic to any medications or substances? Please check box below_____	Yes	No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other_____

WOMEN (please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Do you have, or have you had, any of the following conditions?

	Y	N		Y	N		Y	N		Y	N		Y	N
Heart Disease	☐	☐	Bruise Easily	☐	☐	Tuberculosis	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
Heart Murmur*	☐	☐	Anemia	☐	☐	Cancer	☐	☐	Kidney Problems	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Radiation Treatments	☐	☐	Renal Dialysis	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Chemotherapy	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐
Heart Attack/Failure*	☐	☐	Bleeding Problems	☐	☐	Intestinal Disease	☐	☐	Parathyroid Disease	☐	☐	Convulsions	☐	☐
Cong. Heart Disorder	☐	☐	Leukemia	☐	☐	Ulcers	☐	☐	Arthritis/Gout	☐	☐	Epilepsy/Seizures	☐	☐
Mitral Valve Prolapse*	☐	☐	Blood Transfusion	☐	☐	Recent Weight Loss	☐	☐	Rheumatism	☐	☐	Fainting/Dizziness	☐	☐
Scarlet Fever	☐	☐	Swelling of limbs	☐	☐	Frequent Diarrhea	☐	☐	Pain in Jaw Joints	☐	☐	Glaucoma	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Diabetes	☐	☐	Cortisone Medicine	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problem	☐	☐	Excessive Thirst	☐	☐	Artificial Joint*	☐	☐	Nervousness	☐	☐
Heart Pacemaker*	☐	☐	Shortness of Breath	☐	☐	Hypoglycemia	☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐
Heart Surgery*	☐	☐	Frequent Cough	☐	☐	Liver Disease	☐	☐	AIDS	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A (Infectious)	☐	☐	HIV Positive	☐	☐	Allergies-Medicines	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hepatitis B (Serum)	☐	☐	Shunts	☐	☐	Allergies-Seasonal	☐	☐
Blood Disease	☐	☐	Emphysema	☐	☐	Hepatitis C	☐	☐	Drug Addiction	☐	☐	Hives or Rash	☐	☐

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 of the preceding answers are correct. If I have any changes in 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 _____

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	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____