PATIENT NAME _____

Primary reason for this dental visit ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a regular 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? _____ 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): _____ Yes No
Date of last full mouth x-rays (16 small films or panoramic): _____ Yes No

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 taking any medications, pills, or drugs? Why? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances ? Please check box below

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

WOMEN (please check) ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives

*If yes to any of the starred conditions, please call prior to your appointment ....Pre medication may be required

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
Heart Murmur*	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	X-Ray Treatment (Radiation)	☐	☐	Thyroid Disease	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/Intestinal	☐	☐	Arthritis/Gout	☐	☐	Epilepsy/ Seizures	☐	☐
Mitral Valve Prolapse*	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever*	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw & Joints	☐	☐	Glaucoma	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problem	☐	☐	Diabetes	☐	☐	Artificial Joint*	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐
Heart Surgery*	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Allergies (medicine)	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A (infectious)	☐	☐	Genital Herpes	☐	☐	Allergies(pollen/dust)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B or C	☐	☐	Drug Addiction	☐	☐	Hives or Rash	☐	☐

Have you ever had any other serious illnesses 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 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 _____
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	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____