PATIENT NAME ______________________ **DATE** ____________

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Question		
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

Question		
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 ______

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? 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.

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

Question		
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 - UPDATES