PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: θ **Examination** θ **Emergency** θ **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. _____