**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, 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 ☐ 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 may be required.

| | Yes | No | | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart Disease/Surgery* | ☐ | ☐ | Bruise Easily/Blood Disease | ☐ | ☐ | 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 Treatments (Radiation) | ☐ | ☐ | Thyroid Disease | ☐ | ☐ | Stroke | ☐ | ☐ |
| Heart Attack/Failure | ☐ | ☐ | Hemophilia (Bleeding Problem) | ☐ | ☐ | Chemotherapy | ☐ | ☐ | Parathyroid Disease | ☐ | ☐ | Convulsions | ☐ | ☐ |
| Congenital Heart Disorder | ☐ | ☐ | Leukemia | ☐ | ☐ | Stomach/Intestinal Disease | ☐ | ☐ | Arthritis/Gout | ☐ | ☐ | Epilepsy or 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 | ☐ | ☐ |
| Rheumatic Fever * | ☐ | ☐ | Lung Disease | ☐ | ☐ | Frequent Diarrhea | ☐ | ☐ | Cortisone Medicine | ☐ | ☐ | Tumors or Growths | ☐ | ☐ |
| Artificial Heart Valve * | ☐ | ☐ | Breathing Problem | ☐ | ☐ | Diabetes | ☐ | ☐ | Artificial Joint * | ☐ | ☐ | Nervousness | ☐ | ☐ |
| Heart Pace Maker* | ☐ | ☐ | Shortness of Breath | ☐ | ☐ | Excessive Thirst | ☐ | ☐ | Venereal Disease | ☐ | ☐ | Psychiatric Care | ☐ | ☐ |
| Pulmonary Shunt | ☐ | ☐ | Frequent Cough | ☐ | ☐ | Hypoglycemia | ☐ | ☐ | AIDS | ☐ | ☐ | Alzheimer's Disease | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Hay Fever | ☐ | ☐ | Liver Disease | ☐ | ☐ | HIV Positive | ☐ | ☐ | Allergies (Medicines) | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | Sinus Trouble | ☐ | ☐ | Hepatitis A (Infectious) | ☐ | ☐ | Genital Herpes | ☐ | ☐ | Allergies (Pollen / Dust) | ☐ | ☐ |
| Bacterial Endocarditis | ☐ | ☐ | Asthma | ☐ | ☐ | Hepatitis B or C | ☐ | ☐ | Drug Addiction/Alcoholism | ☐ | ☐ | Hives or Rash | ☐ | ☐ |
| Unexplained Fever | ☐ | ☐ | Bloody Sputum | ☐ | ☐ | Night Sweats | ☐ | ☐ | Tattoos/Body Piercing | ☐ | ☐ | Need Premedication? | ☐ | ☐ |
| | | | | | | | | | | | | Ever taken fen-phen?* | ☐ | ☐ |

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 _____
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. _____ |