

Dental Histories**Patient ID # :** _____

Name : _____ Birth Date: _____
Last First M

- Do you have a specific dental problem? Describe _____ Yes No
- Do you ha 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 cath 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 gring? _____ 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 dentis (optional) : _____ Yes No
- Date of last full mout X-rays (16 small films or panoramic): _____ Yes No

Medical Histories

Curent Physician: _____
Name Address

- Are you now under the care of a Physician? Reason _____
- Have you ever had any serious illness or accident? Explain _____
- List all medications or drugs and dosages that you are taking. _____

(Women) Are you pregnant ? _____ If yes , How many months? _____

Pease circle any of the following that apply to you (now or in the past):

- | | | | |
|--|--|---|--|
| <input type="radio"/> Heart Desease | <input type="radio"/> Tuberculosis, Lung disease | <input type="radio"/> Chemical dependency | <input type="radio"/> Sinus problems |
| <input type="radio"/> Heart Murmur | <input type="radio"/> Diabetes | <input type="radio"/> Abnormal bleeding | <input type="radio"/> Tumors |
| <input type="radio"/> Stroke | <input type="radio"/> Exessive urination, thirst | <input type="radio"/> Fainting spells | <input type="radio"/> Glaucoma |
| <input type="radio"/> Rehumati Fever | <input type="radio"/> Epilepsy, Convulsions | <input type="radio"/> Hepatitis | <input type="radio"/> Readiation therapy |
| <input type="radio"/> Congenital Hearth Defect | <input type="radio"/> Anemia | <input type="radio"/> Jauandice | <input type="radio"/> Mental health care |
| <input type="radio"/> Abnormal Blood Preasure | <input type="radio"/> Thyroid problem | <input type="radio"/> Asthma, Hay fever | <input type="radio"/> Prosthetic implant |
| <input type="radio"/> Ulcers | <input type="radio"/> Venereal disease | <input type="radio"/> Arthritis | <input type="radio"/> Other _____ |

Are you allergic to: Penicillin Codeine Local anesthetic
 Other _____ If none apply check here

Medical Updates*(staff use only)*

Date: _____ Notes: _____

Date: _____ Notes: _____

Patient Signature: _____ Date: _____
(parent or guardian if a minor)

This form completed by: _____ D.D.S. Signature : _____