

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_  
LAST FIRST M

Primary reason for this dental appointment:  Examination  Emergency  Consultation

**DENTAL HISTORY** :

Do you have a specific dental problem? Describe \_\_\_\_\_ **PLEASE CIRCLE**  
 YES NO  
 Do you think you have active decay or gum disease? \_\_\_\_\_ YES NO  
 Do your gums ever bleed? Discuss \_\_\_\_\_ YES NO  
 Do you brush and floss on a routine basis? How often \_\_\_\_\_ YES NO  
 Do you feel nervous about having dental treatment? \_\_\_\_\_ YES NO  
 Have you ever had a bad experience in a dental office? Describe \_\_\_\_\_ YES NO  
 Do you want to keep your remaining teeth? \_\_\_\_\_ YES NO  
 Do you like your smile? Why? \_\_\_\_\_ YES NO  
 Last visit to a Dentist \_\_\_\_\_  
 Reason for visit \_\_\_\_\_  
 Name of previous dentist (optional) \_\_\_\_\_  
 Who referred you to our office? \_\_\_\_\_

**MEDICAL HISTORY** :

Medical doctor's name & address & phone \_\_\_\_\_  
 Are you under a doctor's care now? Why? \_\_\_\_\_ YES NO  
 Have you been hospitalized during the past two years? Why? \_\_\_\_\_ YES NO  
 Are you taking any medications, pills, or drugs? What? \_\_\_\_\_ YES NO  
 Are you allergic to any medications or substance? What? \_\_\_\_\_ YES NO  
 Are you pregnant? (women) \_\_\_\_\_ YES NO

Please **CIRCLE** if you have had any of the following:

- |                         |                               |                       |                        |                    |
|-------------------------|-------------------------------|-----------------------|------------------------|--------------------|
| Heart Trouble           | Chest Pain                    | Scarlet Fever         | Cancer                 | Hypoglycemia       |
| High Blood Pressure     | Shortness of Breath           | Asthma                | Thyroid Disease        | Psychiatric Care   |
| Low Blood Pressure      | Swelling of Feet/Ankles/Hands | Hay Fever             | Parathyroid Disease    | Drug Addiction     |
| Heart Murmur            | Fainting or Dizziness         | Sinus Trouble         | X-Ray or Cobalt Tmt.   | Blood Transfusion  |
| Rheumatic Fever         | Stroke                        | Emphysema             | Chemotherapy/Radiation | Hemophilia         |
| Congenital Heart Lesion | Diabetes                      | Frequent Cough        | Arthritis/Gout         | AIDS               |
| Artificial Heart Valve  | Excessive Thirst              | Lung Disease          | Rheumatism             | Venereal Disease   |
| Heart Pacemaker         | Artificial Joints/Hips        | Tuberculosis          | Pain in Jaw Joints     | Cold Sores         |
| Heart Surgery           | Kidney Trouble                | Liver Disease         | Cortisone Medicine     | Fever Blisters     |
| Blood Disease           | Ulcers                        | Hepatitis A (infect.) | Glaucoma               | Herpes             |
| Anemia                  | Allergies                     | Hepatitis B (serum)   | Epilepsy or Seizures   | Bruise Easily      |
|                         |                               | Yellow Jaundice       | Nervousness            | Sickle Cell Anemia |

Have you had antibiotic pre-medication for prior dental treatment?  YES  NO  
 Have you ever had any other serious illness not circled above?  YES  NO

Please describe in detail \_\_\_\_\_  
 Do you wish to talk to the doctor privately about any problem?  YES  NO

X \_\_\_\_\_ Date \_\_\_\_\_  
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by: Doctor \_\_\_\_\_ Date \_\_\_\_\_ B.P. \_\_\_\_\_

**MEDICAL UPDATES** :

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	DR. _____