PATIENT NAME _____ DATE _____

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
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Rubber ☐ Other _____
WOMEN (Please Check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No
*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
Heart Trouble/Disease	☐☐	Bruise Easily	☐☐	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 (Radiatiion)	☐☐	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 Polapse*	☐☐	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	☐☐
Heart Surgery*	☐☐	Frequent Cough	☐☐	Hypoglycemia	☐☐	AIDS	☐☐	Alzheimer's Disease	☐☐
Hgih Blood Pressure	☐☐	Hay Fever	☐☐	Liver disease	☐☐	HIV Positive	☐☐	Allergies (Medicines)	☐☐
Low Blood Pressure	☐☐	Sinus Trouble	☐☐	Hepatitis A (Infectious)	☐☐	Genital Herpes	☐☐	Allergies (Pollen/Dust)	☐☐
Blood Disease	☐☐	Asthma	☐☐	Hepatitis B or C	☐☐	Drug Addiction	☐☐	Hives or Rash	☐☐

Have you ever had any other serious illiness 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 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)

Review 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. _____
_____	_____	None ☐	_____	____	Dr. _____