

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ 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 think you have active decay or gum disease? \_\_\_\_\_ Yes No
Do your gums ever bleed? Discuss \_\_\_\_\_ Yes No
Are you unhappy with your smile? Why? \_\_\_\_\_ Yes No
Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No
Do you ever have clicking, popping or discomfort in the jaw join? Do you brux or 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 visit, x-rays: \_\_\_\_\_

**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

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? \_\_\_\_\_ Yes No

Are you allergic to any medications or substances? Please check box below \_\_\_\_\_ Yes No

Antibiotics  Codeine  Acrylic  Metal  Latex Rubber  Other \_\_\_\_\_

Women (Please check)  Pregnant/trying to get pregnant  Nursing  Taking oral contraceptives Yes No

Do you now have or have you ever had any of the following? Please check the appropriate boxes.
\*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

Table with 3 columns of conditions and Yes/No checkboxes. Conditions include Heart Disease/Surgery, Irregular Heart Beat, Heart Murmur\*, Angina/Chest Pain, Heart Attack/Failure, Mitral Valve Prolapse\*, Scarlet/Rheumatic Fever\*, Artificial Heart Valve\*, Heart Pace Maker\*, High Blood Pressure, Low Blood Pressure, Bruise Easily/Blood Disease, Thyroid Disease, Asthma/COPD, Tuberculosis, Cancer, Radiation Treatments, Chemotherapy, Ulcers, Diabetes, Liver Disease, Hepatitis A (Infectious), Hepatitis B or C, Kidney Problems, Pain in Jaw Joints, Cortisone Medicine, Artificial Joint\*, HIV +/-AIDS, Drug Addiction/Alcoholism, Cold Sores, Stroke, Epilepsy or Seizures, Fainting or Dizziness, Glaucoma, Psychiatric Care, Ever taken fen-phen?\*

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No
To the best of my knowledge, all the preceding answers are correct. If I have any changed 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 \_\_\_\_\_ Pulse \_\_\_\_\_
History Review and Significant Findings \_\_\_\_\_

**MEDICAL UPDATES**

I have read my MEDICAL HISTORY dates \_\_\_\_\_ and confirm that it adequately states past and present conditions.

DATE EXCEPTIONS PATIENTS SIGNATURE REVIEWED BY
None  \_\_\_\_\_ Dr. \_\_\_\_\_
None  \_\_\_\_\_ Dr. \_\_\_\_\_
None  \_\_\_\_\_ Dr. \_\_\_\_\_