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.**

	Yes	No		Yes	No		Yes	No
Heart Disease/Surgery	❑	❑	Thyroid Disease	❑	❑	Pain in Jaw Joints	❑	❑
Irregular Heart Beat	❑	❑	Asthma/COPD	❑	❑	Cortisone Medicine	❑	❑
Heart Murmur*	❑	❑	Tuberculosis	❑	❑	Artificial Joint*	❑	❑
Angina/Chest Pain	❑	❑	Cancer	❑	❑	HIV +/AIDS	❑	❑
Heart Attack/Failure	❑	❑	Radiation Treatments	❑	❑	Drug Addiction/Alcoholism	❑	❑
Mitral Valve Prolapse*	❑	❑	Chemotherapy	❑	❑	Cold Sores	❑	❑
Scarlet/Rheumatic Fever*	❑	❑	Ulcers	❑	❑	Stroke	❑	❑
Artificial Heart Valve*	❑	❑	Diabetes	❑	❑	Epilepsy or Seizures	❑	❑
Heart Pace Maker*	❑	❑	Liver Disease	❑	❑	Fainting or Dizziness	❑	❑
High Blood Pressure	❑	❑	Hepatitis A (Infectious)	❑	❑	Glaucoma	❑	❑
Low Blood Pressure	❑	❑	Hepatitis B or C	❑	❑	Psychiatric Care	❑	❑
Bruise Easily/Blood Disease	❑	❑	Kidney Problems	❑	❑	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. _____