PATIENT NAME____ 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 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 bleed? Discuss______________________ Yes No
Does food catch between your teeth? Any loose 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 medication, 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 Yes No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other______________

WOMEN (please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss______________

Please indicate YES using a checkmark (√) for any of the following conditions that apply.

☐Heart Trouble/Disease	☐Bruise Easily	☐Emphysema	☐Yellow Jaundice	☐Cold Sores
☐Heart Murmur *	☐Anemia	☐Tuberculosis	☐Kidney Problems	☐Fever Blisters
☐Irregular Hear Beat	☐Excessive Bleeding	☐Cancer	☐Renal Dialysis	☐Herpes
☐Angina/Chest Pain	☐Sickle Cell Disease	☐X-ray Treatments (Radiation)	☐Thyroid Disease	☐Stroke
☐Heart Attack/Failure	☐Chemotherapy	☐Hemophilia (bleeding Problem)	☐Parathyroid Disease	☐Convulsions
☐Congenital Heart Disorder	☐Leukemia	☐Stomach/Intestinal Disease	☐Arthritis/Gout	☐Epilepsy or Seizures
☐Mitral Valve Prolapse*	☐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
☐High Blood Pressure	☐Hay Fever	☐Allergies (Medicines)	☐HIV Positive	☐Liver Disease
☐Low Blood Pressure	☐Allergies (Pollen/Dust)	☐Hepatitis A (Infectious)	☐Genital Herpes	☐Sinus Trouble
☐Blood Disease	☐Asthma	☐Hepatitis B (Serum)	☐Drug Addiction	☐Hives or Rash

Have you ever had any other serious illness 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______________________________________ ______________
PATIENT SIGNATURE (PARENT OR GUARDIAN) DATE

Reviewed by Doctor______________________ Date______________
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	REVIEWED BY
________	______________	☐None	______________	DR.________
________	______________	☐None	______________	DR.________
________	______________	☐None	______________	DR.________
________	______________	☐None	______________	DR.________
________	______________	☐None	______________	DR.________

DENTAL AND MEDICAL HISTORIES • UPDATES