

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

DENTAL HISTORY

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 _____ DATE _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

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.

Table with 4 columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, REVIEWED BY. Includes 'No ne' checkboxes for each row.