Patient name_____ Date_____

Primary reason for this appointment is: Examination Emergency Consultation

DENTAL HISTORY

Do you have a specific dental problem? Describe_____ Yes No
Do you have dental examination on a routine basis? Last visit_____ Yes No
Do you brush and floss on a routine basis? Discuss_____ Yes No
Do your gums ever bleed? Discuss_____ 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 bruise or grin? _____ Yes No
Have your past experience in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growth 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_____ Yes No
Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____Yes No
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 you appointment… Premeditation may be required'

YES/NO Heart Trouble or Disease	YES/NO Hemophilia (Bleeding Problem)	YES/NO X-Ray Treatments (Radiations)	YES/NO Parathyroid Disease	YES/NO Epilepsy or Seizures
Heart Murmur	Anemia	Tuberculosis	Yellow Jaundice	Cold Sores
Irregular Heart Beal	Bruise Easily	Emphysema	Kidney Problems	Fever Blisters
Angina/Chest Pain	Excessive Disease	Cancer	Renal Dialysis	Herpes
Heart Attack/Failure	Leukemia	Chemotherapy	Arthritis/Gout	Stroke
Congenital Heart Disorder	Sickle Cell Disease	Stomach/Intestinal Disease	Rheumatism	Convulsions
Mitral Valve Prolepses	Record Blood Transfusion	Ulcers	Pain in Jaw Joints	Fainting or Dizziness
Scarlet Fever	Swelling of Limbs	Record Weight Loss	Cortisone Medicine	Tumor or Growing
Rheumatic fever	Lungs Desease	Frequent Diarrhea	Articial Joint	Nervousness
Arterial Heart Valve	Breathing Problem	Diabetes	Venereal Disease	Psychiatric Care
Heart Pace Maker	Shortness of Breath	Excessive Thirst	AIDS	Alzheimer's Disease
Heart Surgery	Frequent Cough	Hypoglycemia	HIV positive	Allergies (Medicine)
High Blood Pressure	Hay Fever	Liver Disease	Genital Herpes	Hives or Rash
Low Blood Pressure	Sinus Trouble	Hepatitis A (infectious)	Drug Addition	Allergies (Pollen/Dust)
Blood Disease	Asthma	Hepatitis B or C	Thyroid Disease	Glaucoma

Have you ever had any other serious illness not checked above? Discuss_____
Do you wish to talk to the dentist privately about any problem? _____

To the best of my knowledge, all of the above information is correct. If I have any changes in my health status or if my medicine change, I shall inform the dentist and staff at the next appointment.

✖_____ Date _____

Patient Signature (Parent or Guardian)

Reviewed by Doctor: _____ Date _____ BP _____
History reviewed by the and significant findings

_____

_____

Medical Updates
I have read my medical history and confirm that it adequately states past and present conditions:_____
PATIENT SIGNATURE AND DATE