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