Patient Name ______________________________ **Date** ______________

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History:

Please Circle

Question		
Do you have a specific dental problem? Describe ____________	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 ever bleed? Discuss ____________	Yes	No
Do you like 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 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

Medical History:

Question		
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 mediations, pills or drugs? What? ________ Ever taken fen-phen?* ____________	Yes	No
Are you on a special diet? Discuss ____________	Yes	No
Are you allergic to any mediations 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 ☐ Take oral contraceptives – Discuss ____________ Yes No

Do you now have or have ever had any of the following? Please check appreciate boxes/
* If yes to any of the starred conditions, please call prior to your appointment… premedication may be required.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Heart Murmur*	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	X-ray Treatments	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia	☐	☐	Chemotherapy	☐	☐	Parathyroid Diseases	☐	☐	Epilepsy	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Stomach/GI Disease	☐	☐	Arthritis/Gout	☐	☐	Seizures	☐	☐
Mitral Valve Prolapsed*	☐	☐	Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Fainting	☐	☐
Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐	Dizziness	☐	☐
Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Glaucoma	☐	☐
Artificial Heart Valve*	☐	☐	Breathing Problem	☐	☐	Diabetes	☐	☐	Artificial Joint*	☐	☐	Tumors/Growths	☐	☐
Heart Pace Maker*	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐	Nervousness	☐	☐
Heart Surgery	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Psychiatric Care	☐	☐
High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV positive	☐	☐	Alzheimer's Disease	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A	☐	☐	Genital Herpes	☐	☐	Allergies (meds)	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B or C	☐	☐	Cold Sores	☐	☐	Allergies (pollen/dust)	☐	☐
Unexplained Fever	☐	☐	Bloody Sputum	☐	☐	Night Sweats	☐	☐	Drug Addiction	☐	☐	Hives or Rash	☐	☐

Have you ever had other serious illness not checked above? Discuss ____________ Yes No
Do you wish to talk to the dentist privately about any problems?____________ Yes No

To best of my knowledge, all the preceding answers are correct. If I have any changes in my health or if my medicines change, I shall inform the dentist at the next appointment without fail.

X ______________________________ Date: ______________
PATIENT SIGNATURE (Parent of 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

Date	Exceptions		Patient's Signature	BP	Reviewed By
______	______________	None ☐	______________	______	Dr. ______________
______	______________	None ☐	______________	______	Dr. ______________
______	______________	None ☐	______________	______	Dr. ______________
______	______________	None ☐	______________	______	Dr. ______________
______	______________	None ☐	______________	______	Dr. ______________
______	______________	None ☐	______________	______	Dr. ______________
______	______________	None ☐	______________	______	Dr. ______________