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 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 want to keep your remaining 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 medications, aspirin, vitamins, herbals, 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 ☐ Milk ☐ Other ______________________

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss ______ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Methemoglobinemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Aredia I.V. Reclast I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder*	☐	☐	Recent Blood Transfusion	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Swelling of Limbs	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Lung Disease	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Breathing Problem	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Shortness of Breath	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Frequent Cough	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Bloody Sputum	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Emphysema	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	Cancer	☐	☐	Protease Inhibitor	☐	☐	Sleep Apnea	☐	☐	Cochlear implants?	☐	☐
Coronary Stent*	☐	☐	X-Ray Treatments (Radiation)	☐	☐									

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 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 ______ BP ______ Pulse ______

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	PULSE	REVIEWED BY
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.
		None ☐				Dr.

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