**PATIENT NAME:**_____ **DATE:**_____

Primary reason for this dental appointment: ( ) Examination ( ) Emergency ( ) Consultation

## DENTAL HISTORY

- Do you have a specific dental problem? Describe_____
- Do you have dental examinations on a routine basis? Last visit_____
- Do you think you have active decay or gum disease?_____
- Do you brush and floss on a routine basis? Discuss_____
- Do your gums ever bleed? Discuss_____
- Do you like your smile? Why?_____
- Does food catch between your teeth? Any loose teeth?_____
- Do you want to keep your remaining teeth?_____
- Do you ever have clicking, popping or discomfort in jaw joint? Do you brux or grind?_____
- Have your past experiences in a dental office always been positive?_____
- Do you smoke or chew? Any sores or growths in your mouth? Discuss_____
- Name of previous dentist:_____
- Date of your last full mouth xray (16 small films or panoramic)_____

## MEDICAL HISTORY

- Are you under a physicians care now? Why?_____
- Have you ever been hospitalized or had a major operation? Discuss_____
- Have you ever had a serious injury to your head or neck? Discuss_____
- Are you currently taking any medications, pills, drugs, supplements, etc.? What?_____
- Are you on a special diet? Discuss_____
- Are you allergic to any medications or substances? ( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Latex Rubber ( ) Acrylic ( ) Metal
  ( ) OTHER - Please list:_____

***WOMEN*** Please Check if ( ) Pregnant ( ) Trying to get pregnant ( ) Nursing ( ) Taking oral contraceptives - What?_____

**Do you now have or have you ever had any of the following? Please check all appropriate boxes.**
*If YES to any of the starred (*) conditions, please call prior to your appointment. PreMedication may be required.*

| Yes | No | | Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | * Heart Trouble/Disease | ❑ | ❑ | Bruise Easily | ❑ | ❑ | Emphysema | ❑ | ❑ | Yellow Jaundice | ❑ | ❑ | Cold Sores |
| ❑ | ❑ | * Heart Murmur | ❑ | ❑ | Anemia | ❑ | ❑ | Tuberculosis | ❑ | ❑ | Kidney Problems | ❑ | ❑ | Fever Blisters |
| ❑ | ❑ | Irregular Heart Beat | ❑ | ❑ | Excessive Bleeding | ❑ | ❑ | Cancer | ❑ | ❑ | Renal Dialysis | ❑ | ❑ | Herpes |
| ❑ | ❑ | Angina / Chest Pain | ❑ | ❑ | Sickle Cell Disease | ❑ | ❑ | Radiation (X-Ray Treatments) | ❑ | ❑ | Thyroid Disease | ❑ | ❑ | Stroke |
| ❑ | ❑ | Heart Attack / Failure | ❑ | ❑ | Hemophilia (Bleeding Problem) | ❑ | ❑ | Chemotherapy | ❑ | ❑ | 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 |
| ❑ | ❑ | * Artificial Heart Valve | ❑ | ❑ | Swelling of Limbs | ❑ | ❑ | Recent Weight Loss | ❑ | ❑ | Pain in Jaw Joints | ❑ | ❑ | Glaucoma |
| ❑ | ❑ | Scarlet Fever | ❑ | ❑ | Lung Disease | ❑ | ❑ | Diabetes | ❑ | ❑ | Cortisone Medicine | ❑ | ❑ | Tumors or Growths |
| ❑ | ❑ | * Rheumatic Fever | ❑ | ❑ | Breathing Problems | ❑ | ❑ | Excessive Thirst | ❑ | ❑ | * Artificial Joints | ❑ | ❑ | Nervousness |
| ❑ | ❑ | * Heart Pace Maker | ❑ | ❑ | Shortness of Breath | ❑ | ❑ | Hypoglycemia | ❑ | ❑ | Venereal Disease | ❑ | ❑ | Psychiatric Care |
| ❑ | ❑ | Heart Surgery | ❑ | ❑ | Frequent Cough | ❑ | ❑ | Liver Disease | ❑ | ❑ | AIDS | ❑ | ❑ | Alzheimer 's Disease |
| ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Hay Fever | ❑ | ❑ | Hepatitis A (Infectious) | ❑ | ❑ | HIV Positive | ❑ | ❑ | Allergies (Medication) |
| ❑ | ❑ | Low Blood Pressure | ❑ | ❑ | Sinus Trouble | ❑ | ❑ | Hepatitis B or C | ❑ | ❑ | Genital Herpes | ❑ | ❑ | Allergies (Pollen/Dust) |
| ❑ | ❑ | Blood Disease | ❑ | ❑ | Asthma | ❑ | ❑ | Night Sweats | ❑ | ❑ | Drug Addiction | ❑ | ❑ | Hives or Rash |
| ❑ | ❑ | Unexplained Fever | ❑ | ❑ | Bloody Sputum | ❑ | ❑ | Frequent Diarrhea | ❑ | ❑ | Tattoos | ❑ | ❑ | Other_____ |

- Have you ever had any other serious illness not listed above? Discuss_____
- Do you wish to speak with the Dentist privately about any problems? _____

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

Signature:_____ Please Print Name_____ Date_____
Patient/Guardian/Parent Signature

Reviewed by Doctor_____ Date_____ BP_____

History Review and Significant Findings_____

## MEDICAL UPDATES

I HAVE READ MY HEALTH HISTORY dated_____ and confirm that it adequately states past and present conditions.

| DATE | EXCEPTIONS | | PATIENT/GUARDIAN SIGNATURE | BP | REVIEWED BY DR. |
|---|---|---|---|---|---|
| _____ | _____ | NONE ❑ | _____ | _____ | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | _____ |
| _____ | _____ | NONE ❑ | _____ | _____ | _____ |