

PATIENT NAME _____ DATE OF BIRTH _____ 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? _____ 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
 Aspirin Penicillin Codeine Acrylic Metal Latex Rubber 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? Please check 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 | | | |
|---------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|
| Heart Trouble/Disease | <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur * | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular Heart Beat | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Renal Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> |
| Anginal/Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> | <input type="checkbox"/> | X-Ray Treatments (Radiation) | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack/Failure | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia (Bleeding Problem) | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Parathyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Heart Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Intestinal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/Gout | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse * | <input type="checkbox"/> | <input type="checkbox"/> | Recent Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of Limbs | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever * | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Medicine | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Heart Valve * | <input type="checkbox"/> | <input type="checkbox"/> | Breathing Problem | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint * | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Pace Maker * | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Cough | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | Allergies (Medicines) | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A (Infectious) | <input type="checkbox"/> | <input type="checkbox"/> | Genital Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Allergies (Pollen / Dust) | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B or C | <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> | Hives or Rash | <input type="checkbox"/> | <input type="checkbox"/> |

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

X _____ Date _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

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 <input type="checkbox"/> | _____ | _____ | Dr. _____ |
| _____ | None <input type="checkbox"/> | _____ | _____ | Dr. _____ |
| _____ | None <input type="checkbox"/> | _____ | _____ | Dr. _____ |
| _____ | None <input type="checkbox"/> | _____ | _____ | Dr. _____ |