

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

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? Explain _____ Yes No
Do your gums ever bleed? Explain _____ 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 the dental office always been positive? _____ Yes No
Do you smoke or chew tobacco? How many years? _____ How many packs a day? _____ Yes No
Any sores or growths in your mouth? _____ Yes No
Name of previous dentist (optional): _____ Yes No
Date of last full mouth x-rays (16 small films or panoramic): _____ Yes No

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? Explain _____ Yes No
Have you ever had a serious injury to your head or neck? Explain _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Yes No
Are you on a special diet? Explain _____ 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] 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 stated conditions, please call prior to appointment... premedication may be required.

Table with 6 columns: Condition, Yes, No, Condition, Yes, No, Condition, Yes, No, Condition, Yes, No, Condition, Yes, No. Rows include AIDS, Allergies (Medicines), Allergies (Pollen / Dust), Alzheimer's Disease, Anemia, Angina/Chest Pain, Arthritis/Gout, Artificial Heart Valve*, Artificial joint*, Asthma, Bacterial Endocarditis*, Bloody Sputum, Breathing Problem, Bruise Easily/Blood Disease, Cancer, Chemotherapy, Cold Sores, Congenital heart disease, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction/ Alcoholism, Emphysema, Epilepsy or Seizures, Ever taken fen-phen?*, Excessive Bleeding, Excessive Thirst, Fainting or Dizziness, Fever Blisters, Frequent Cough, Frequent Diarrhea, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart disease/surgery*, Heart Murmur*, Heart Pace Maker*, Hemophilia (Bleeding Problem), Hepatitis A (Infectious), Hepatitis B or C, Herpes, High Blood Pressure, HIV Positive, Hives or Rash, Hypoglycemia, Irregular Heart Beat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse*, Need Premedication?, Nervousness, Night Sweats, Pain in jaw joints, Parathyroid disease, Psychiatric Care, Pulmonary shunt, Recent Blood Transfusion, Recent Weight Loss, Renal Disease, Rheumatic fever*, Rheumatism, Scarlet Fever, Shortness Of Breath, Sickle Cell Disease, Sinus Trouble, Stomach/ Intestinal Disease, Stroke, Swelling of Limbs, Tattoos/Body Piercing, Thyroid disease, Tuberculosis, Tumors or Growths, Ulcers, Unexplained Fever, Venereal Disease, X-ray Treatments (Radiation), Yellow jaundice.

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 _____
History Reviewed and significant findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and conform that it adequately states past and present conditions.

Table with 4 columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, REVIEWED BY. Rows for multiple updates with 'None' in the signature column.