

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 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.

Table with 8 columns: Condition, Yes, No, Condition, Yes, No, Condition, Yes, No, Condition, Yes, No. Rows include Heart Disease/Surgery*, Heart Murmur or Defect*, Irregular Heart Beat, Angina/Chest Pain, Heart Attack/Failure, Congenital Heart Disorder*, Mitral Valve Prolapse*, Scarlet Fever, Rheumatic Fever*, Artificial Heart Valve*, Heart Pace Maker*, Pulmonary Shunt*, High Blood Pressure, Low Blood Pressure, Bacterial Endocarditis*, Unexplained Fever, Bruise Easily/Blood Disease, Anemia, and Coronary Stent*.

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.

Table with 5 columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, PULSE, REVIEWED BY. Rows for signature and review.