

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.

Table with 5 columns of conditions and Yes/No checkboxes. Includes: 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, Coronary Stent*, Excessive Bleeding, Sickle Cell Disease, Hemophilia, Methemoglobinemia, Leukemia, Recent Blood Transfusion, Swelling of Limbs, Lung Disease, Breathing Problem, Shortness of Breath, Frequent Cough, Hay Fever, Sinus Trouble, Asthma, Bloody Sputum, Emphysema, Tuberculosis, Cancer, X-Ray Treatments (Radiation), Chemotherapy, Osteoporosis, Bisphosphonates, Osteonecrosis of Jaw, Aredia I.V. Reclast I.V., Zometa I.V., Fosamax, Actonel, Boniva, Stomach/Intestinal Disease, Ulcers, Recent Weight Loss, Frequent Diarrhea, Diabetes, Excessive Thirst, Hypoglycemia, Liver Disease, Hepatitis A (Infectious), Hepatitis B or C, Protease Inhibitor, Night Sweats, Yellow Jaundice, Kidney Problems, Renal Dialysis, Thyroid Disease, Parathyroid Disease, Arthritis/Gout, Rheumatism, Pain in Jaw Joints, Cortisone Medicine, Artificial Joint*, Sexually Transmitted Disease, AIDS, HIV Positive, Genital Herpes, Drug Addiction/Alcoholism, Tattoos/Body Piercing, Sleep Apnea, Cold Sores, Fever Blisters, Herpes, Stroke, Convulsions, Epilepsy or Seizures, Fainting or Dizziness, Glaucoma, Tumors or Growths, Nervousness, Psychiatric Care, Alzheimer's Disease, Allergies (Medicines), Allergies (Pollen / Dust), Hives or Rash, Need Premedication?, Ever taken fen-phen?*, Cochlear Implants?.

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 columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, PULSE, REVIEWED BY. Includes rows for None [] and Dr. _____