

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

Would you describe your present dental health as good? Comments _____ YES NO

Do you brush and floss on a routine basis? Discuss _____ YES NO

Do you want to keep your remaining teeth? _____ YES NO

Do you like your smile? Why? _____ YES NO

Do you think you have active decay or gum disease? _____ YES NO

Do your gums ever bleed? Discuss _____ YES NO

Do you feel nervous about having dental treatment? _____ YES NO

Have you ever had a bad experience in a dental office? Describe _____ YES NO

Name of previous dentist (optional) _____ Who referred you to our office? _____ YES NO

Do you ever brux or grind your teeth? Discuss _____ YES NO

Have you ever had orthodontic treatment (tooth straightening)? _____ YES NO

Do you ever have clicking, popping or discomfort in the jaw joints (TMJD)? Discuss _____ YES NO

MEDICAL HISTORY

Medical doctor's name _____ YES NO

Are you under a doctor's care now? Why? _____ YES NO

Have you been hospitalized or received a blood transfusion? When? _____ YES NO

Are you taking any medications, pills, or drugs? What? _____ YES NO

Are you allergic to any medications or substance? _____ (Penicillin, Codeine, Metal, Acrylic, Latex Rubber, Etc.?) What? _____ YES NO

Are you pregnant? (women) _____ YES NO

Please CIRCLE if you have had any of the following:

Heart Trouble
High Blood Pressure
Low Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesion
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Blood Disease
Anemia

Chest Pain
Shortness of Breath
Swelling of Feet/Ankles/Hands
Fainting or Dizziness
Stroke
Diabetes
Excessive Thirst
Artificial Joints/Hips
Kidney Trouble
Ulcers
Allergies

Scarlet Fever
Asthma
Hay Fever
Sinus Trouble
Emphysema
Frequent Cough
Lung Disease
Tuberculosis
Liver Disease
Hepatitis A (infect.)
Hepatitis B (serum)
Yellow Jaundice
Recent Weight Loss

Cancer
Thyroid Disease
Parathyroid Disease
X-ray or Cobalt Tmt
Chemotherapy/Radiation
Arthritis/Gout
Rheumatism
Pain in Jaw Joints
Cortisone Medicine
Glaucoma
Epilepsy or Seizures
Nervousness
Alzheimer's Disease

Hypoglycemia
Psychiatric Care
Drug Addiction
Blood Transfusion
Hemophilia
AIDS (HIV)
Venereal Disease
Cold Sores
Fever Blisters
Herpes
Bruise Easily
Sickle Cell Anemia
Mitral Valve Prolapse

Have you ever had any other serious illness not circled above? _____ ☐ YES ☐ NO

Please describe in detail _____ ☐ YES ☐ NO

Do you wish to talk to the doctor privately about any problem? _____ ☐ YES ☐ NO

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

To the best of my knowledge, all of 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.

Reviewed by: Doctor _____ Date _____ B.P. _____

MEDICAL UPDATES

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

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	None ☐	_____	_____	DR. _____
_____	None ☐	_____	_____	DR. _____
_____	None ☐	_____	_____	DR. _____
_____	None ☐	_____	_____	DR. _____
_____	None ☐	_____	_____	DR. _____
_____	None ☐	_____	_____	DR. _____
_____	None ☐	_____	_____	DR. _____

DENTAL AND MEDICAL HISTORIES — UPDATES

Medication and Surgical History

Name: _____ Date: _____

List medications you are currently taking. Include both prescription and over-the-counter drugs, as well as any supplements you use regularly.

Medication Name	Frequency	Dose	Purpose

List any medical conditions and all past surgeries.

List any allergies and your reactions.

Allergy	Reaction