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? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does any 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 of x-rays (18 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? _____ Yes No
Women (please check) ☐Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Yes No
Are you allergic to any medications or substances? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐Acrylic ☐ Metal ☐ Latex Rubber Yes No
☐ Milk ☐ Other _____

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease / Defect / Surgery	☐	☐	Coronary Stent	☐	☐	Cancer/Tumors/ Growths	☐	☐	Protease Inhibitor	☐	☐	HIV	☐	☐
Angina / Chest Pain	☐	☐	Excessive Bleeding	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
Heart Attack / Failure	☐	☐	Sickle Cell Disease	☐	☐	Chemotherapy	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Scarlet Fever	☐	☐	Hemophilia	☐	☐	Osteoporosis	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Methemogloinemia	☐	☐	Aredia I.V. Reclast I.V	☐	☐	Thyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Artificial Heart Valve	☐	☐	Leukemia	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Fainting or Dizziness	☐	☐
Heart Pace Maker	☐	☐	Recent Blood Transfusion	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Pulmonary Shunt	☐	☐	Swelling of Limbs	☐	☐	Stomach/Intestinal Disease	☐	☐	Cortisone Medicine	☐	☐	Psychiatric Care	☐	☐
High Blood Pressure	☐	☐	Lung Disease/COPD	☐	☐	Ulcers	☐	☐	Artificial Joint	☐	☐	Alzheimer's Disease	☐	☐
Low Blood Pressure	☐	☐	Hay Fever	☐	☐	Diabetes	☐	☐	Sexually Transmitted Diseases	☐	☐	Allergies (Medicines)	☐	☐
Bacterial Endocarditis	☐	☐	Sinus Trouble	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Need Premedication?	☐	☐
Bruise Easily / Blood Disease	☐	☐	Asthma	☐	☐	Liver Disease	☐	☐	Hepatitis A, B or C	☐	☐	Ever taken fen-phen?	☐	☐
Anemia	☐	☐	Tuberculosis	☐	☐									

Do you wish to talk to the dentist privately about any problem/ illness not listed above? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or my medicines change, I shall inform the dentist and staff at the next appointment.

X_____ **Date**_____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date_____ BP_____ Pulse_____

History Review and Significant Findings _____

_____

_____