

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, 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 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 starred conditions, please call prior to your appointment... premedication may be required.

Heart Disease/Surgery*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily/Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina/Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	X-Ray Treatments (Radiation)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia (Bleeding Problem)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aredia I.V.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Zometa I.V.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pace Maker*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joint *	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pulmonary Shunt	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (Medicines)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (Pollen / Dust)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bacterial Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unexplained Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bloody Sputum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A (Infectious)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction/Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Need Premedication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tattoos/Body Piercing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ever taken fen-phen?*	<input type="checkbox"/> Yes <input type="checkbox"/> No

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.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____