

PATIENT NAME _____ DATE _____

DENTAL HISTORY

Do you have a specific dental problem? Describe _____ Please Circle Yes No
When was your last dental examination? _____
Do you think you have gum disease or active decay? _____ Yes No
Do you brush and floss regularly? Describe _____ Yes No
Do you ever have bleeding gums? Describe _____ Yes No
Are you happy with your smile? Why? _____ Yes No
Does food catch in your teeth? Do you have any loose teeth? _____ Yes No
Do you want to keep your teeth? _____ Yes No
Do you have jaw pain, popping, or clicking? Do you grind your teeth? _____ Yes No
Have your previous dental visits always been positive? _____ Yes No
Do you smoke, chew, or have any sores in your mouth? Describe _____ Yes No
Date of last panoramic or full mouth x-rays (16 films) _____

MEDICAL HISTORY

Are you under the care of a physician? Why? _____ Who? _____ Phone _____ Yes No
Have you had a major operation or been hospitalized? Describe _____ Yes No
Have you ever seriously injured your neck or head? Describe _____ Yes No
Do you take any medications, aspirin, vitamins, drugs, etc? What? _____ Yes No
Do you follow a special diet? Describe _____ Yes No
Do you have allergies to any medications/substances? List or check below _____ Yes No
[] Aspirin [] Penicillin [] Codeine [] Acrylic [] Metal [] Latex Rubber [] Other _____
WOMEN: [] Pregnant or trying [] Nursing [] Taking Oral Contraceptives - Describe _____ Yes No

Do you now have or ever had any of the following? Do you take any of the listed medications? Please check "yes" to all items that pertain to you. *If yes to any starred item, please call prior to appointment - premedication or medication changes may be necessary.

Yes Yes Yes Yes Yes
Heart disease/Surgery* Excessive Bleeding Chemotherapy Night Sweats Cold Sores
Heart Murmur/Defect* Sickle Cell Disease Osteoporosis Yellow Jaundice Fever Blisters
Irregular Heart Beat Hemophilia/Bleeding Bisphosphonates Kidney Problems Herpes
Angina/Chest Pain Leukemia Jaw Osteonecrosis Renal Stroke Stroke
Heart Attack/Failure Recent Blood Transfusion Aredia I.V. Thyroid Disease Convulsions
Congenital Heart Dis.* Swelling of Limbs Zometa I.V. Parathyroid Disease Epilepsy/Seizure
Mitral Valve Prolapse* Lung Disease Fosamax, Actonel, Boniva Arthritis/Gout Fainting/Dizziness
Scarlet Fever Breathing Problems Stomach/Intestinal Disease Rheumatism Glaucoma
Rheumatic Fever* Shortness of Breath Ulcers Pain in Jaw Joints Tumors or Growths
Artificial Heart Valve* Frequent Cough Recent Weight Loss Cortisone Medicine Nervousness
Pulmonary Shunt* Hay Fever Frequent Diarrhea Artificial Joint* Psychiatric Care
High Blood Pressure Sinus Trouble Diabetes Venereal Disease Alzheimer's Disease
Low Blood Pressure Asthma Excessive Thirst AIDS Allergies (Medicines)
Bacterial Endocarditis* Bloody Sputum Hypoglycemia HIV Positive Allergies (Pollen/Dust)
Unexplained Fever Emphysema Liver Disease Genital Herpes Hives or Rash
Bruise Easily/Blood Disease Tuberculosis Hepatitis A (Infectious) Drug Addiction/Alcoholism Need Premedication?
Anemia Cancer Hepatitis B or C Tattoos/Body Piercing Ever Taken fen-phen?
Coronary Stent* X-ray treatments (Radiation) Protease Inhibitor Cochlear Implants?

Have you ever had any other serious illness not checked above? Explain _____ Yes No
Is there anything you wish to talk to the Doctor about privately? _____ Yes No

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

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 Dr.
None Dr.
None Dr.
None Dr.
None Dr.
None Dr.