

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 4 columns of conditions and Yes/No checkboxes. Conditions include Heart Disease/Surgery\*, Excessive Bleeding, Chemotherapy, Night Sweats, Cold Sores, etc.

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