Patient Name _____ Date _____

Primary reason for this appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History **Circle One**

Do you have a specific dental problem? If so, describe_____ Yes No
Do you have dental examinations on a routine basis? Date of 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? If not, why?. Yes No
Does food get caught 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 tobacco? Any sores or growths in your mouth? Discuss_____ Yes No
Name of previous dentist (Optional)_____ Yes No
Date of last full mouth x-rays (Sixteen small films or a panoramic)_____ Yes No

Medical History

Are you under a physician's care now? If so, why?_____Who?_____Phone_____ Yes No
Have you ever been hospitalized or had a major operation? 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 as appropriate) ☐ Pregnant/trying to get pregnant ☐ Nursing
☐ Taking oral contraceptives. Discuss_____

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 you answered yes to any condition followed by a star (*), please call the office prior to your appointment as premedication or changes in medication may be required.

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

Have you ever had any other serious illness not listed above? Discuss_____ ☐Yes ☐No
Do you wish to talk to the dentist privately about any problem or concern?_____ ☐Yes ☐No

To the best of my knowledge all of the preceding answers are correct. I shall inform the dentist/staff at the next appointment of any changes in my health status or if there are any changes in the medications I am taking.

X_____ Date:_____
Signature (Patient, 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
_____	_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	_____	Dr. _____
_____	_____	_____	_____	_____	Dr. _____