

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

Primary reason for this dental appointment  Examination  Emergency  Consultation

**Dental History** Please Circle

Do you have a specific dental problem? \_\_\_\_\_ 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? \_\_\_\_\_ 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? \_\_\_\_\_ 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 \_\_\_\_\_ 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 below \_\_\_\_\_ Yes No

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex Rubber  Other \_\_\_\_\_ Yes No

Have you ever taken bisphosphonate medication (such as Actonel, Aredia, Boniva, Fosamax, Zometa, Bonefos, Ostac, Skelid, Didronel) \_\_\_\_\_ 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

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease*	◆	◆	Hemophilia(Bleeding Problem)	◆	◆	Frequent Diarrhea	◆	◆
Heart Murmur*	◆	◆	Leukemia	◆	◆	Diabetes	◆	◆
Irregular Heart Beat	◆	◆	Recent Blood Transfusion	◆	◆	Excessive Thirst	◆	◆
Angina/Chest Pain	◆	◆	Swelling of Limbs	◆	◆	Hypoglycemia	◆	◆
Heart Attack/Failure	◆	◆	Lung Disease	◆	◆	Liver Disease	◆	◆
Congenital Heart Disorder	◆	◆	Breathing Problem	◆	◆	Hepatitis A(Infectious)	◆	◆
Mitral Valve Prolapse*	◆	◆	Shortness of Breath	◆	◆	Hepatitis B or C	◆	◆
Scarlet Fever	◆	◆	Frequent Cough	◆	◆	Yellow Jaundice	◆	◆
Rheumatic Fever *	◆	◆	Hay Fever	◆	◆	Kidney Problems	◆	◆
Artificial Heart Valve*	◆	◆	Sinus Trouble	◆	◆	Renal Dialysis	◆	◆
Heart Pace Maker*	◆	◆	Asthma	◆	◆	Thyroid Disease	◆	◆
Heart Surgery*	◆	◆	Emphysema	◆	◆	Parathyroid Disease	◆	◆
High Blood Pressure	◆	◆	Tuberculosis	◆	◆	Arthritis/Gout	◆	◆
Low Blood Pressure	◆	◆	Cancer	◆	◆	Rheumatism	◆	◆
Blood Disease	◆	◆	Radiation	◆	◆	Pain in Jaw Joints	◆	◆
Bruise Easily	◆	◆	Chemotherapy	◆	◆	Cortisone Medicine	◆	◆
Anemia	◆	◆	Stomach/Intestinal Disease	◆	◆	Artificial Joint*	◆	◆
Excessive Bleeding	◆	◆	Ulcers	◆	◆	Venereal Disease	◆	◆
Sickle Cell Disease	◆	◆	Recent Weight Loss	◆	◆	AIDS	◆	◆

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 of 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 \_\_\_\_\_

History Review and Significant Findings: \_\_\_\_\_