

Name: \_\_\_\_\_  
LAST FIRST MID.

**Reason for this appointment**  Routine Exam  Emergency / Pain  Consult

**DENTAL HISTORY**

Do you have a dental problem? What is it? \_\_\_\_\_

Do you like your smile? If no, why not? \_\_\_\_\_

Have you had good experiences with dentists? If not, why? \_\_\_\_\_

How long ago did you have x-rays taken? \_\_\_\_\_

Do your gums bleed?	Yes No
Do you brush/floss every day?	Yes No
Do you have any decayed teeth?	Yes No
Do you have gum problems?	Yes No
Do you have mouth sores?	Yes No

Do you get regular dental exams?	Yes No
Do you catch food between teeth?	Yes No
Do you want to keep your teeth?	Yes No
Do your jaws click or pop?	Yes No
Do you smoke or chew?	Yes No

**MEDICAL HISTORY**

Are you under a physicians care? Why? \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone # \_\_\_\_\_

Have you been in the hospital recently? Why? \_\_\_\_\_

Are you allergic to:  Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Other: \_\_\_\_\_

Are you taking prescription medications? Please list: \_\_\_\_\_

Have you had any neck or back injuries? \_\_\_\_\_

Are you on a special diet? What? Why? \_\_\_\_\_

**Women:**

Are you taking oral contraceptives? Yes No

Are you pregnant or trying to be? Yes No

Are you nursing? Yes No

**Do you now have or have you ever had any of the following?**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Heart Trouble / Disease   | <input type="checkbox"/> Leukemia                     | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Genital Herpes          |
| <input type="checkbox"/> Heart Murmur **           | <input type="checkbox"/> Recent Blood Transfusion     | <input type="checkbox"/> Excessive Thirst         | <input type="checkbox"/> Drug Addiction          |
| <input type="checkbox"/> Irregular Heart Beat      | <input type="checkbox"/> Swelling of Limbs            | <input type="checkbox"/> Hypoglycemia             | <input type="checkbox"/> Cold Sores              |
| <input type="checkbox"/> Angina/Chest Pain         | <input type="checkbox"/> Lung Disease                 | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Fever Blisters          |
| <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Breathing Problem            | <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Herpes                  |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Shortness of Breath          | <input type="checkbox"/> Hepatitis B or C         | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Mitral Valve Prolapse **  | <input type="checkbox"/> Frequent Cough               | <input type="checkbox"/> Yellow Jaundice          | <input type="checkbox"/> Convulsions             |
| <input type="checkbox"/> Scarlet Fever             | <input type="checkbox"/> Hay Fever                    | <input type="checkbox"/> Kidney Problems          | <input type="checkbox"/> Epilepsy or Seizures    |
| <input type="checkbox"/> Rheumatic Fever **        | <input type="checkbox"/> Sinus Trouble                | <input type="checkbox"/> Renal Dialysis           | <input type="checkbox"/> Fainting or Dizziness   |
| <input type="checkbox"/> Artificial Heart Valve ** | <input type="checkbox"/> Asthema                      | <input type="checkbox"/> Thyroid Disease          | <input type="checkbox"/> Glaucoma                |
| <input type="checkbox"/> Heart Pace Maker **       | <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Parathyroid Disease      | <input type="checkbox"/> Tumors or Growths       |
| <input type="checkbox"/> Heart Surgery **          | <input type="checkbox"/> Tuberculosis                 | <input type="checkbox"/> Arthritis/Gout           | <input type="checkbox"/> Nervousness             |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Rheumatism               | <input type="checkbox"/> Psychiatric Care        |
| <input type="checkbox"/> Low Blood Pressure        | <input type="checkbox"/> X-ray Treatments (Radiation) | <input type="checkbox"/> Pain in Jaw Joints       | <input type="checkbox"/> Alzheimer's Disease     |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Chemotherapy                 | <input type="checkbox"/> Cortisone Medicine       | <input type="checkbox"/> Allergies (Medicines)   |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Stomach/Intestinal Disease   | <input type="checkbox"/> Artificial Joint **      | <input type="checkbox"/> Allergies (Pollen/Dust) |
| <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Ulcers                       | <input type="checkbox"/> Venereal Disease         | <input type="checkbox"/> Hives or Rash           |
| <input type="checkbox"/> Sickle Cell Anemia        | <input type="checkbox"/> Recent Weight Loss           | <input type="checkbox"/> AIDS                     | <input type="checkbox"/> Bruise Easily           |
| <input type="checkbox"/> Hemophilia (Bleeding)     | <input type="checkbox"/> Frequent Diarrhea            | <input type="checkbox"/> HIV Positive             |  |

Any illness or condition not listed above? What? \_\_\_\_\_

To the best of my knowledge, all answers above are current and accurate. I shall inform this dental office if there are any changes in my medical status or medicines.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient, Parent, or Guardian

Reviewed by Doctor / Staff: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL UPDATES**

Change in status: \_\_\_\_\_ Date: \_\_\_\_\_ Dr.: \_\_\_\_\_

Change in status: \_\_\_\_\_ Date: \_\_\_\_\_ Dr.: \_\_\_\_\_

Change in status: \_\_\_\_\_ Date: \_\_\_\_\_ Dr.: \_\_\_\_\_