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? ______________________

Question	
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?

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

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.: ______________