PATIENT NAME _____ **DATE** _____
LAST FIRST M

Primary reason for this dental appointment: ❒ Examination ❒ Emergency ❒ Consultation

DENTAL HISTORY

Do you have a specific dental problem? Describe _____	YES	NO
Do you have dental examinations on a routine basis? Last visit _____	YES	NO
Would you describe your present dental health as good? Comments _____	YES	NO
Do you think you have active decay or gum disease? _____	YES	NO
Do your gums ever bleed? Discuss _____	YES	NO
Do you brush and floss on a routine basis? Discuss _____	YES	NO
Do you feel nervous about having dental treatment? _____	YES	NO
Have you ever had a bad experience in a dental office? Describe _____	YES	NO
Do you want to keep your remaining teeth? _____	YES	NO
Do you like your smile? Why? _____	YES	NO
Name of previous dentist _____	YES	NO
Do you ever brux or grind your teeth? Discuss _____	YES	NO
Have you ever had orthodontic treatment (tooth straightening)? _____	YES	NO
Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Discuss _____	YES	NO

MEDICAL HISTORY

Medical doctor's name _____		
Are you under a doctor's care now? Why? _____	YES	NO
Have you been hospitalized during the past two years? Why? _____	YES	NO
Are you taking any medications, pills, or drugs? What? _____	YES	NO
Are you allergic to any medications or substance? What? _____	YES	NO
Are you pregnant? (Women) _____	YES	NO

Please CIRCLE if you have had any of the following:

Heart Trouble	Swelling of Feet/Ankles/	Sinus Trouble	X-ray or Cobalt Tmt.	Blood Transfusion
High Blood Pressure	Hands	Emphysema	Chemotherapy/Radiation	Hemophilia
Low Blood Pressure	Fainting or Dizziness	Frequent Cough	Arthritis/Gout	AIDS
Heart Murmur	Stroke	Lung Disease	Rheumatism	Venereal Disease
Rheumatic Fever	Diabetes	Tuberculosis	Pain in Jaw Joints	Cold Sores
Congenital Heart Lesion	Excessive Thirst	Liver Disease	Cortisone Medicine	Fever Blisters
Artificial Heart Valve	Artificial Joints/Hips	Hepatitis A (infec.)	Glaucoma	Herpes
Heart Pacemaker	Kidney Trouble	Hepatitis B (serum)	Epilepsy or Seizures	Bruise Easily
Heart Surgery	Ulcers	Yellow Jaundice	Nervousness	Sickle Cell Anemia
Blood Disease	Allergies	HIV Positive	Mitral Valve Prolapse	
Anemia	Scarlet Fever	Cancer	Hypglycemia	
Chest Pain	Asthma	Thyroid Disease	Psychiatric Care	
Shortness of Breath	Hay Fever	Parathyroid Disease	Drug Addiction	

Have you ever had any other serious illness not circled above? _____	YES	NO
Please describe in detail _____		
Do you wish to talk to the doctor privately about any problem? _____	YES	NO

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by: Doctor _____ Date _____ B.P. _____

MEDICAL UPDATES:

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ❒	_____	DR.	_____
_____	_____	None ❒	_____	DR.	_____
_____	_____	None ❒	_____	DR.	_____
_____	_____	None ❒	_____	DR.	_____
_____	_____	None ❒	_____	DR.	_____
_____	_____	None ❒	_____	DR.	_____
_____	_____	None ❒	_____	DR.	_____