

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ 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? Discuss _____ 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? 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? 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? _____ Who? _____ Phone _____ 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? _____ Ever taken fen-Phen? * _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you taking aspirin daily or are you on any blood thinners? _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
[] Aspirin [] Penicillin [] Codeine [] Acrylic [] Metal [] Latex Rubber [] Other _____
Women (please check): [] Pregnant/trying to get pregnant [] Nursing [] Taking oral contraceptives Discuss _____ 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 apointment... premedication may be required.

Table with 4 columns of conditions and Yes/No checkboxes. Conditions include Heart Trouble/Disease, Bruise Easily, Emphysema, Yellow Jaundice, etc.

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 knowlege, all 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 _____ BP _____
History Review and Significant Findings _____

Medical updates

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

Table with 4 columns: DATE, EXCEPTIONS, PATIENTS SIGNATURE, BP, REVIEWED BY. Includes rows for None and Dr. signatures.