

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 a dental examination 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 every 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 been positive? \_\_\_\_\_ Yes No
Do you smoke or chew tobacco? Any sores or growths in your mouth? Discuss \_\_\_\_\_ Yes No
Name of previous dentist (optional): \_\_\_\_\_
Date of last full mouth x-rays (16 small files of 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, aspirin, vitamins, herbals, 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 box below \_\_\_\_\_ Yes No
Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk 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? Do you take any or these medications? Please check appropriate boxes.
\*If yes to any of the starred conditions, please call prior to your appointment...Premedication or changes in medication may be required.

Table with 10 columns: Condition, Yes, No, Condition, Yes, No, Condition, Yes, No, Condition, Yes, No. Includes conditions like Heart Disease, Chemotherapy, Night Sweats, Cold Sores, 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

X \_\_\_\_\_ Date \_\_\_\_\_
Patient Signature (Parent or Guardian)

Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_ PULSE \_\_\_\_\_

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 6 columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, PULSE, REVIEWED BY. Includes rows for medical updates.