PATIENT NAME _____ **DATE**_____

Primary reason for this dental appointment ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? _____ 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?_____ 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?_____ 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_____ 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?_____ Yes No
Are you on a special diet? Discuss_____ Yes No
Are you allergic to any medications or substances? Please check below _____ Yes No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____ Yes No
Have you ever taken bisphosphanate medication(such as Actonel, Aredia, Boniva, Fosamax, Zometa, Bonefos, Ostac, Skelid, Didronel) _____ Yes No
Are you currently taking, or have you taken in the past 24 hours: Plavix, Coumadin, Warfarin, NSAIDS, Celecoxib, Etodolac, Mefenamic acid, Piroxicam, Aspirin, Pradaxa or any other medicine with a side effect of increased bleeding?_____ 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 appointment… premedication may be required

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease*	♦	♦	Hemophilia(Bleeding Problem)	♦	♦	Frequent Diarrhea	♦	♦	HIV Positive	♦	♦
Heart Murmur*	♦	♦	Leukemia	♦	♦	Diabetes	♦	♦	Genital Herpes	♦	♦
Irregular Heart Beat	♦	♦	Recent Blood Transfusion	♦	♦	Excessive Thirst	♦	♦	Drug Addiction	♦	♦
Angina/Chest Pain	♦	♦	Swelling of Limbs	♦	♦	Hypoglycemia	♦	♦	Cold Sores	♦	♦
Heart Attack/Failure	♦	♦	Lung Disease	♦	♦	Liver Disease	♦	♦	Fever Blisters	♦	♦
Congenital Heart Disorder	♦	♦	Breathing Problem	♦	♦	Hepatitis A(Infectious)	♦	♦	Herpes	♦	♦
Mitral Valve Prolapse*	♦	♦	Shortness of Breath	♦	♦	Hepatitis B or C	♦	♦	Stroke	♦	♦
Scarlet Fever	♦	♦	Frequent Cough	♦	♦	Yellow Jaundice	♦	♦	Convulsions	♦	♦
Rheumatic Fever *	♦	♦	Hay Fever	♦	♦	Kidney Problems	♦	♦	Epilepsy or Seizures	♦	♦
Artificial Heart Valve*	♦	♦	Sinus Trouble	♦	♦	Renal Dialysis	♦	♦	Fainting or Dizziness	♦	♦
Heart Pace Maker*	♦	♦	Asthma	♦	♦	Thyroid Disease	♦	♦	Glaucoma	♦	♦
Heart Surgery*	♦	♦	Emphysema	♦	♦	Parathyroid Disease	♦	♦	Tumors or Growths	♦	♦
High Blood Pressure	♦	♦	Tuberculosis	♦	♦	Arthritis/Gout	♦	♦	Nervousness	♦	♦
Low Blood Pressure	♦	♦	Cancer	♦	♦	Rheumatism	♦	♦	Psychiatric Care	♦	♦
Blood Disease	♦	♦	Radiation	♦	♦	Pain in Jaw Joints	♦	♦	Alzheimer's Disease	♦	♦
Bruise Easily	♦	♦	Chemotherapy	♦	♦	Cortisone Medicine	♦	♦	Allergies (Medicine)	♦	♦
Anemia	♦	♦	Stomach/Intestinal Disease	♦	♦	Artificial Joint*	♦	♦	Allergies (Pollen/Dust)	♦	♦
Excessive Bleeding	♦	♦	Ulcers	♦	♦	Venereal Disease	♦	♦	Hives or Rash	♦	♦
Sickle Cell Disease	♦	♦	Recent Weight Loss	♦	♦	AIDS	♦	♦	Sleep Apnea	♦	♦
									Snoring	♦	♦

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 knowledge, all of 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 _____
History Review and Significant Findings: _____
_____