

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation B/P _____ Pulse _____

Dental History

NOTES

YES NO

Do you have a specific dental problem? Describe: _____

When was your last dental visit? _____

When was your last dental cleaning? _____

What was done at that time? _____

Were X-rays taken? _____

Have you had, or do you currently have any of the following. (please mark appropriate box)

| | | | |
|--|--|--|---|
| <input type="checkbox"/> dental extractions | <input type="checkbox"/> fixed bridge | <input type="checkbox"/> loose teeth | <input type="checkbox"/> food catching in teeth |
| <input type="checkbox"/> gum surgery | <input type="checkbox"/> removable partial denture | <input type="checkbox"/> bruxing/grinding | <input type="checkbox"/> chipped teeth |
| <input type="checkbox"/> bleeding gums/gum disease | <input type="checkbox"/> fixed denture | <input type="checkbox"/> jaw popping/clicking/discomfort | <input type="checkbox"/> orthodontic work |

Do you use any form of tobacco? (specify) _____

Do you consume alcoholic beverages? _____

Have you had any trouble associated with any previous dental treatment?(explain) _____

If you feel uneasy about dental exams, is there any specific thing we can do to help? _____

Medical History

Name of primary physician _____ Office phone _____ Date of last exam _____

Pharmacy _____ Phone # _____

Have you ever been hospitalized or had an operation? Explain _____

Have you ever had a serious injury to your head or neck? Explain _____

Are you taking any medications, pills, or drugs? Please List _____

| Medication | Reason | Medication | Reason |
|------------|--------|------------|--------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Are you allergic to any medications or materials? List _____

WOMEN (please Check): pregnant/trying to get pregnant Nursing Taking oral contraceptives

Do you have or have you ever had any of the following (check appropriate boxes):

* If yes to any of the starred conditions please call prior to your appointment, pre-medication may be required

| | | | |
|--|---|---|---|
| <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Excess Bleeding | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> X-Ray Treatments | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Congenital Heart | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach/intestinal | <input type="checkbox"/> Cortisone/Steroid |
| <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Artificial Joint |
| <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Hepatitis type_ | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Back/Neck pain | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tumors/Growths | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shunts/Catheters |

Have you ever had any other serious illness or condition not checked above? Describe _____

Do you wish to talk to the dentist privately about any problem? _____

To the best of my knowledge, all of the preceding answers are correct

Patient Signature (Parent/Guardian) _____ Date _____ Dentist Signature _____ Date _____

MEDICAL/DENTAL HISTORY