PATIENT NAME_____ DATE_____

Primary reason for this dental appointment: ❑ Examination ❑ Emergency ❑ Consultation B/P_____ Pulse_____

Dental History

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)

❑ dental extractions	❑ fixed bridge	❑ loose teeth	❑ food catching in teeth
❑ gum surgery	❑ removable partial denture	❑ bruxing/grinding	❑ chipped teeth
❑ bleeding gums/gum disease	❑ fixed denture	❑ jaw popping/clicking/discomfort	❑ 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 ar 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

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

NOTES

MEDICAL/DENTAL HISTORY