PATIENT NAME _____ **DATE** _____
LAST FIRST M

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
Would you describe your present dental health as good? Comments _____	YES NO
Do you brush and floss on a routine basis? Discuss _____	YES NO
Do you want to keep your remaining teeth? _____	YES NO
Do you like your smile? Why? _____	YES NO
Do you think you have active decay or gum disease? _____	YES NO
Do your gums ever bleed? Discuss _____	YES NO
Do you feel nervous about having dental treatment? _____	YES NO
Have you ever had a bad experience in a dental office? Describe _____	YES NO
Name of previous dentist (optional) _____ Who referred you to our office? _____	
Do you ever brux or grind your teeth? Discuss _____	YES NO
Have you ever had orthodontic treatment (tooth straightening)? _____	YES NO
Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Discuss _____	YES NO

MEDICAL HISTORY

Medical doctor's name _____

Are you under a doctor's care now? Why? _____	YES NO
Have you been hospitalized or received a blood transfusion? When? _____	YES NO
Are you taking any medications, pills, or drugs? What? _____ (Penicillin, Codeine, Latex Rubber, Etc.?) What?	YES NO
Are you allergic to any medications or substance? _____	YES NO
Are you pregnant? (women) _____	YES NO

Please CIRCLE if you have had any of the following:

		Scarlet Fever	Cancer	Hypoglycemia
		Asthma	Thyroid Disease	Psychiatric Care
Heart Trouble	Chest Pain	Hay Fever	Parathyroid Disease	Drug Addiction
High Blood Pressure	Shortness of Breath	Sinus Trouble	X-ray or Cobalt Tmt.	Blood Transfusion
Low Blood Pressure	Swelling of Feet/Ankles/Hands	Emphysema	Chemotherapy/Radiation	Hemophilia
Heart Murmur	Fainting or Dizziness	Frequent Cough	Arthritis/Gout	AIDS (HIV)
Rheumatic Fever	Stroke	Lung Disease	Rheumatism	Venereal Disease
Congenital Heart Lesion	Diabetes	Tuberculosis	Pain in Jaw Joints	Cold Sores
Artificial Heart Valve	Excessive Thirst	Liver Disease	Cortisone Medicine	Fever Blisters
Heart Pacemaker	Artificial Joints/Hips	Hepatitis A (infec.)	Glaucoma	Herpes
Heart Surgery	Kidney Trouble	Hepatitis B (serum)	Epilepsy or Seizures	Bruise Easily
Blood Disease	Ulcers	Yellow Jaundice	Nervousness	Sickle Cell Anemia
Anemia	Allergies	Recent Weight Loss	Alzheimer's Disease	

Have you ever had any other serious illness not circled above? _____ ☐ YES ☐ NO

Please describe in detail _____

Do you wish to talk to the doctor privately about any problem? _____ ☐ YES ☐ NO

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by: Doctor _____ Date _____ B.P _____

MEDICAL UPDATES

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

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ☐	_____	_____	DR. _____
_____	_____	None ☐	_____	_____	DR. _____
_____	_____	None ☐	_____	_____	DR. _____
_____	_____	None ☐	_____	_____	DR. _____
_____	_____	None ☐	_____	_____	DR. _____
_____	_____	None ☐	_____	_____	DR. _____
_____	_____	None ☐	_____	_____	DR. _____