PATIENT NAME____**DATE**_______________

PRIMARY REASON FOR THIS DENTAL APPOINTMENT : EXAMINATION __ EMERGENCY__ CONSUTATION__

DENTAL HISTORY

DO YOU HAVE A SPECIFIC DENTAL PROBLEM? DESCRIBE____
DO YOU HAVE DENTAL EXAMINATIONS ON A ROUTIME BASIS? _____ DATE OF LAST VISIT ______/______/__________
DO YOU THINK YOU HAVE ACTIVE DECAY OR GUM DISEASE? ____
DO YOU BRUSH AND FLOSS ON A ROUTINE BASIS? ____
DO YOUR GUMS EVER BLEED? ____
DO YOU LIKE YOUR SMILE? ____
DO YOU CATCH FOOD BETWEEN YOUR TEETH? LOOSE TEETH? ____
DO YOU WANT TO KEEP YOUR REMAINING TEETH? ____
DO YOU EVER HAVE CLICKING, POPPING OR DISCOMFORT IN THE JAW JOINT? DO YOU BRUX OR GRIND? ______________
HAVE YOUR PAST EXPERIENCES IN A DENTAL OFFICE ALWAYS BEEN POSITIVE? ________________________________
DO YOU SMOKE OR CHEW? ANY SORES OR GROWTHS IN YOUR MOUTH? ____________________________________
NAME OF PREVIOUS DENTIST ____
DATE OF LAST FULL MOUTH X-RAYS (16 SMALL FILMS OR PANORAMIC) __________________________________

MEDICAL HISTORY

ARE YOU UNDER A PHYSICIAN'S CARE NOW? WHY? ____
HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION? ____
HAVE YOU EVER HAD A SERIOUS INJURY TO YOUR HEAD OR NECK? ____
ARE YOU TAKING ANY MEDICATIONS, PILLS, DRUGS? ____
ARE YOU ALERGIC TO ANY MEDICATIONS?____
__ASPRIN __ PENICILLIN __CODEINE __ACYRLIC __ METAL __LATEX RUBBER __OTHER________________________
WOMEN: __PREGNANT/ TRYING __NURSING __TAKING ORAL CONTRACEPTIVES
DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
*IF YES TO ANY OF THE STARRED CONDITIONS PLEASE CALL PRIOR TO YOUR APPOINTMENT –PRE MEDS MAY BE NEEDED.

__HEART DISEASE
__HEART MURMUR*
__IRREGULAR HEART
__ANGINA
__CONGENITAL HEART
__MITRAL VALVE PROLAPSE*
__SCARLET FEVER
__RHEUMATIC FEVER*
__ARTIFICIAL HEART VALVE*
__HEART PACE MAKER*
__HEART SURGERY*
__HIGH BLOOD PRESSURE
__LOW BLOOD PRESSURE
__BLOOD DISEASE
__BRUISE EASILY
__ANEMIA
__EXCESSIVE BLEEDING
__SICKLE CELL DISEASE
__HEMOPHILIA
__LEUKEMIA

__RECENT BLOOD TRANSFUSION
__SWELLING OF LIMBS
__LUNG DISEASE
__SWELLING OF LIMBS
__LUNG DISEASE
__BREATHING PROBLEM
__SHORTNESS OF BREATH
__FREQUENT COUGH
__HAY FEVER
__SINUS TROUBLE
__ASTHMA
__EMPHYSEM
__TUBERCULOSIS
__CANCER
__RADIATION
__CHEMOTHERAPY
__STOMACHE/INTEST. DIS.
__ULCERS
__RECENT WEIGHT LOSS
__FREQUENT DIARRHEA

__DIABETES
__EXCESSIVE THIRST
__HYPOGLYCEMIA
__LIVE DISEASE
__HEPATITIS A
__HEPATITIS BOR C
__YELLOW JAUNDICE
__KIDNEY PROBLEMS
__RENAL DIALYSIS
__THYROID DISEASE
__PARATHYROID DISEASE
__ARTHRITIS/GOUT
__RHEUMATISM
__PAIN IN JAW JOINTS
__CORTISONE MEDICINE
__ARTIFICAL JOINT
__VENEREAL DISEASE
__AIDS
__HIV POSITIVE
__GENITAL HERPES

__DRUG ADDICTION
__COLD SORES
__FEVER BLISTERS
__HERPES
__STROKE
__CONVULSIONS
__EPILEPSY OR SEIZURES
__FAINTING OR DIZZINESS
__GLAUCOMA
__TUMORS OR GROWTHS
__NERVOUSNESS
__PSYCHIATRIC CARE
__ALZHEIMER'S DISEASE
__ALLERGIES (MEDICATION)
__ALLERGIES (SEASONAL)
__HIVES OR RASH

HAVE YOU EVER HAD ANY OTHER SERIOUS ILLNESS NOT CHEKED ABOVE? _______________________________________
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. If any changes in myhealth status or medicines change, I shall inform the dentist/staff at the next appointment.

X____ DATE ___/___/______
PATIENT SIGNATURE (PARENT OR GUARDIAN)

REVIEWED BY DOCTOR____ DATE ___/___/______ BP_____