

PATIENT NAME _____ DATE _____

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
 Do you have dental examinations on a routine basis? Date of last visit _____ Yes No
 Do you think you have active decay or gum disease? _____ Yes No
 Do you brush and floss on a daily basis? _____ Yes No
 Do your gums occasionally bleed? _____ Yes No
 Would you like to change anything about your smile? _____ Yes No
 Would you like to have whiter teeth? _____ Yes No
 Does food catch between your teeth? Any loose teeth? _____ Yes No
 Do you have clicking, popping or discomfort in the jaw joint? Do you clench or grind? _____ Yes No
 Have your past experiences in a dental office always been positive? _____ Yes No
 Are you interested in utilizing Nitrous Oxide gas during treatment? _____ Yes No
 Do you smoke or chew tobacco? Any sores or growths in your mouth? _____ Yes No
 Name and location of previous dentist _____

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ Who? _____ Ph: _____ Yes No
 Have you ever been hospitalized or had a major operation? _____ Yes No
 Are you taking any medications, pills, or drugs? List _____ Yes No
 Are you allergic to any medications or substances? List _____ Yes No

Women (please check): Pregnant Trying to get pregnant Nursing Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check all boxes.
 If yes to any of the starred (*) conditions, pre-medication may be necessary.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint*	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	AIDS / HIV+	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes I, II (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sore/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, C (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker*	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Medication	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Latex	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Taken Bisphosphonates	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Rash	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had any other serious illness not checked above? List _____ Yes No

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ Date _____ BP _____
 History Review and Significant Findings _____ P _____

MEDICAL UPDATES

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

Date	Changes		Patient's Signature	BP/P	Dr.
_____	_____	<input type="checkbox"/> None	_____	_____	_____
_____	_____	<input type="checkbox"/> None	_____	_____	_____
_____	_____	<input type="checkbox"/> None	_____	_____	_____