Patient Name____ **Date**________________

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 think you have active decay or gum disease? ______________________________ **YES NO**

Do your gums ever bleed? Discuss ______________________________ **YES NO**

Do you brush and floss on a routine basis? 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**

Do you want to keep your remaining teeth? ______________________________ **YES NO**

Do you like your smile? Why? ______________________________ **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 during the past two years? Why? ______________________________ **YES NO**

Are you taking any medications, pills, or drugs? What? ______________________________ **YES NO**

Are you allergic to any medications or substance? What? ______________________________ **YES NO**

Are you pregnant? (women) ______________________________ **YES NO**

Please CIRCLE if you have had any of the following:

Heart Trouble	**Chest Pain**	**Scarlet Fever**	**Cancer**	**Psychiatric Care**
High Blood Pressure	**Shortness of Breath**	**Asthma**	**Thyroid Disease**	**Drug Addiction**
Low Blood Pressure	**Swelling of Fee/ Ankles/Hands**	**Sinus Trouble**	**Parathyroid Disease**	**Blood Transfusion**
Heart Murmur	**Fainting or Dizziness**	**Hay Fever**	**Chemotherapy/Radiation**	**Hemophilia**
Rheumatic Fever	**Stroke**	**Emphysema**	**X-ray or Cobalt TX**	**Bruise Easily**
Congenial Heart Lesion	**Diabetes**	**Frequent Cough**	**Arthritis/Grout**	**AIDS**
Artificial Heart Valve	**Excessive Thirst**	**Tuberculosis**	**Rheumatism**	**HIV Positive**
Heart Pacemaker	**Artificial Joints/Hips**	**Liver Disease**	**Pain in Jaw Joints**	**Venereal Disease**
Heart Surgery	**Kidney Troubles**	**Hepatitis A (infec.)**	**Cortisone Medication**	**Cold Sores**
Blood Disease	**Ulcers**	**Hepatitis B(Serum)**	**Glaucoma**	**Fever Blisters**
Anemia	**Allergies**	**Yellow Jaundice**	**Nervousness**	**Herpes**
Sickle Cell Anemia	**Hypoglycemia**			

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**

Patient Signature (Parent or Guardian) ______________________________ Date _____________

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 SIGNATURE	B.P.	REVIEWED BY
________	______________________	None ☐	______________________	____________	DR. ____________
________	______________________	None ☐	______________________	____________	DR. ____________
________	______________________	None ☐	______________________	____________	DR. ____________
________	______________________	None ☐	______________________	____________	DR. ____________
________	______________________	None ☐	______________________	____________	DR. ____________
________	______________________	None ☐	______________________	____________	DR. ____________