**Patient Name**_____ **Date**_____

Emergency contact Name _____Phone number_____

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? Describe_____ **YES NO**
Do you brush and floss on a routine basis? Describe _____ **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**
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**
Name of previous dentist (optional) _____ How did you hear about our office? _____

**MEDICAL HISTORY**

Medical doctor's name _____Office phone_____
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? Please list your medications on the back of this form. **YES NO**
Are you allergic to any medications or substance? What? _____ **YES NO**
Are you taking Bisphosphonates (Fosamax, Reclast, Boniva, Actonel etc.)_____ **YES NO**
Are you allergic to Latex?_____ **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 Feet,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/Gout** | **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 | | | Parent Signature | BP | | |
|---|---|---|---|---|---|---|---|
| | | None | | | | | |
| | | None | | | | | |
| | | None | | | | | |
| | | None | | | | | |
| | | None | | | | | |
| | | None | | | | | |

## LIST OF MEDICATIONS

DATE_____

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