Patient Name ____Date __________________

Primary reason for this dental appointment: Examination Emergency Consultation

DENTAL HISTORY

Do you have a specific dental problem? Describe ____________________________ YES NO
Do you have a dental examination on a routine basis? Last visit ________________ 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? __________________________________ YES NO
Do you like your smile? Why? ____ YES NO
Does food catch between your teeth? Any loose teeth? ________________________ YES NO
Do you want to keep your remaining teeth? _________________________________ YES NO
Do you ever have clicking, popping or discomfort in the jaw? Do you brux or grind? YES NO
Have your past experiences in a dental office always been positive? _____________ YES NO
Do you smoke or chew? Any sores or growths in your mouth? _________________ YES NO
Name of previous dentist (optional) _______________________________________ YES NO
Date of last full mouth x-rays (16 small films or panoramic) ____________________

MEDICAL HISTORY

Are you under a physician's care now? Why? ______________ Who? ____________ YES NO
Physician's phone number ______________________
Have you ever been hospitalized or had a major operation? Discuss ______________ YES NO
Have you ever had a serious injury to your head or neck? Discuss _______________ YES NO
Are you taking any medication, pills or drugs? What? _________________________ YES NO
Are you on a special diet? Discuss ____ YES NO
Have you ever taken phen-phen? ____ YES NO
Are you allergic to any medications or substances? Please circle below
Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other __________________
WOMEN (please circle) Pregnant Trying to get pregnant Nursing Taking oral contraceptives
If Pregnant how many months? __________________________

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CIRCLE ANY THAT APPLY. IF YES TO ANY OF THE STARRED CONDITIONS, PROPHYLACTIC PREMEDICATION MAY BE NECESSARY.

Heart Trouble/Disease*	Bruise Easily	Emphysema	Yellow Jaundice	Cold Sores
Heart Murmur*	Anemia	Tuberculosis	Kidney Problems	Fever Blisters
Irregular Heart Beat	Cancer	Renal Dialysis	Herpes	Excessive Bleeding
Angina/Chest Pain	X-ray Treatment	Thyroid Disease	Blood Disease	Sickle Cell Disease
Heart Attack/ Failure	Hemophilia	Chemotherapy	Convulsions	Parathyroid Disease
Congenital Heart Disorder	Leukemia	Arthritis/ Gout	Epilepsy/Seizure	Stroke
Mitral Valve Prolapse*	Ulcers	Rheumatism	Fainting/Dizzy	Recent Blood Transfusion
Scarlet Fever	Weight Loss	Glaucoma	Pain in Jaw Joints	Swelling of Limbs Recent
Rheumatic Fever*	Lung Disease	Frequent Diarrhea	Tumors/Growth	Cortisone Medicine
Artificial Heart Valve	Diabetes	Artificial Joint*	Nervousness	Breathing Problem
Heart Pace Maker*	Excessive Thirst	Venereal Disease	Psychiatric Care	Shortness of Breath
Heart Surgery	Frequent Cough	Hypoglycemia	AIDS	Alzheimer's
High Blood Pressure	Hay Fever	Liver Disease	HIV Positive	Allergies (Meds)
Low Blood Pressure	Sinus Trouble	Hepatitis A	Genital Herpes	Allergies (Dust)
Stomach/Intestinal Disease	Asthma	Hepatitis B or C	Hives/Rash	Drug/Alcohol Addiction
Unexplained Fever	Bloody Sputum	Night Sweats	Need Premed	Multiple Sclerosis

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

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X____ Date ________________________________
Patient signature (Parent or Guardian)