PATIENT NAME_____DATE_____

DENTAL HISTORY

Do you have a specific dental problem? Describe _____
Do you have dental examinations on a regular basis? Last visit?_____
Do you think you have active decay or gum disease?_____
Do your gums bleed? Discuss_____
Do you smoke or chew? Do you have any sores in your mouth?_____
Do you brush and floss on a routine basis?_____
Name of previous dentist (optional)?_____
Date of last full mouth x-rays(16 small films or a panoramic)_____

MEDICAL HISTORY

Physician Name_____
Address_____ Phone_____
Are you under a physician's care now?Why?_____
Have you ever been hospitalized or had a major operation? Discuss_____
Have you ever had a serious injury to your head or neck? Discuss_____
Are you taking any medications, pills, or drugs? What?_____

Are you allergic to any medications or substances? Please circle below.

Aspirin Penicillin Codeine Latex Sulfa Erythromycin Other _____

Women: (Please check) ☐ Pregnant/ Trying to get Pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Do you have now/ or have you ever had any of the following? Please place an **X** next to anything that pertains to you.

	X		X		X		X		X
Angina/Chest Pain		Sickle Cell Disease		Radiation		Thyroid Disease		Stroke	
Artificial Heart Valve		Breathing Problems		Diabetes		Artificial Joint		Nervousness	
Blood Disease		Asthma		Hepatitis B or C		Drug Addiction		Hives or Rash	
Congenital Heart		Leukemia		Intestinal Disease		Arthritis/Gout		Epilepsy or Seizures	
Heart Attack/Failure		Hemophilia (Bleeding		Chemotherapy		Parathyroid Disease		Convulsions	
Heart Murmur		Anemia		Tuberculosis		Kidney Disease		Fever Blisters	
Heart Pace Maker		Shortness of Breath		Excessive Thirst		Venereal Disease		Psychiatric Care	
Heart Surgery		Frequent Cough		Hypoglycemia		AIDS		Alzheimer's Disease	
Heart Trouble		Bruise Easily		Emphysema		Yellow Jaundice		Cold Sores	
High Blood Pressure		Hay Fever		Liver Disease		HIV Positive		Allergies/Medicines	
Irregular Heart Beat		Excessive Bleeding		Cancer		Renal Dialysis		Herpes	
Low Blood Pressure		Sinus Trouble		Hepatitis A(Infectn)		Genital Herpes		Allergies/Pollen,Dust	
Mitral Valve Prolaspse		Recent BloodTransfusn		Ulcers		Rheumatism		Fainting /Dizziness	
Rheumatic Fever		Lung Disease		Frequent Diarrhea		Cortisone Medicine		Tumors or Growths	
Scarlet Fever		Swelling of Limbs		Recent Weight Loss		Pain in Jaw Joints		Glaucoma	
Unexplained Fever		Bloody Sputum		Night Sweats		Tattoos		Pre-Medication Needed	

Have you ever had any other serious illness not checked above? Discuss_____
Do you wish to talk to the dentist privately about any problem?_____

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.

X_____Date_____
Patient Signature (Parent or Guardian)