Patient Name: _____ Date: _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY:

Do you have a specific dental problem?	Describe: _____
Do you have dental examinations on a routine basis? ☐ Yes ☐ No	Last Visit: _____
Do you think you have active decay or gum disease?	☐ Yes ☐ No
Do you brush and floss on a routine basis?	☐ Yes ☐ No
Do your gums ever bleed?	☐ Yes ☐ No
Do you like your smile?	☐ 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 joint? Do you brux or grind?	☐ Yes ☐ No
Have your past experience in a dental office always been positive?	☐ Yes ☐ No
Do you smoke or chew? Any sores or growths in your mouth?	☐ Yes ☐ No

Previous Dentist (optional) _____ Date of last full mouth x-rays (16 small films or panoramic): _____

MEDICAL HISTORY:

Are you under a physician's care now? ☐ Yes ☐ No Why? _____	Who? _____ Phone: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No	Discuss: _____
Have you ever had a serious injury to your head or neck? ☐ Yes ☐ No	Discuss: _____
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? ☐ Yes ☐ No	What: _____
Are you on a special diet? ☐ Yes ☐ No	Discuss: _____

Are you allergic to any medications or substances? (Check all that apply)

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk Other: _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives | Discuss: _____

Do you now have, or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes. If yes to any of the * starred conditions, please call prior to your appointment. Premedication or changes in medication may be required.

☐ Heart Disease/Surgery*	☐ Excessive Bleeding	☐ Chemotherapy	☐ Night Sweats	☐ Cold Sores
☐ Heart Murmur/Defect*	☐ Sickle Cell Disease	☐ Osteoporosis	☐ Yellow Jaundice	☐ Fever Blisters
☐ Irregular Heart Beat	☐ Hemophilia	☐ Bisphosphonates	☐ Kidney Problems	☐ Herpes
☐ Angina/Chest Pain	☐ Methemoglobinemia	☐ Osteonecrosis of Jaw	☐ Renal Dialysis	☐ Stroke
☐ Heart Attack/Failure	☐ Leukemia	☐ Aredia I.V. Reclast I.V.	☐ Thyroid Disease	☐ Convulsions
☐ Congenital Heart Disorder*	☐ Recent Blood Transfusion	☐ Zometa I.V.	☐ Parathyroid Disease	☐ Epilepsy or Seizures
☐ Mitral Valve Prolapse*	☐ Swelling of Limbs	☐ Fosamax, Actonel, Boniva	☐ Arthritis/Gout	☐ Fainting or Dizziness
☐ Scarlet Fever	☐ Lung Disease	☐ Stomach/Intestinal Disease	☐ Rheumatism	☐ Glaucoma
☐ Rheumatic Fever*	☐ Breathing Problems	☐ Ulcers	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Artificial Heart Valve*	☐ Shortness of Breath	☐ Recent Weight Loss	☐ Cortisone Medicine	☐ Nervousness
☐ Heart Pace Maker*	☐ Frequent Cough	☐ Frequent Diarrhea	☐ Artificial Joint*	☐ Psychiatric Care
☐ Pulmonary Shunt*	☐ Hay Fever	☐ Diabetes	☐ Sexually Transmitted Disease	☐ Alzheimer's Disease
☐ High Blood Pressure	☐ Sinus Trouble	☐ Excessive Thirst	☐ AIDS	☐ Allergies (Medicines)
☐ Low Blood Pressure	☐ Asthma	☐ Hypoglycemia	☐ HIV Positive	☐ Allergies (Pollen / Dust)
☐ Bacterial Endocarditis*	☐ Blood Sputum	☐ Liver Disease	☐ Genital Herpes	☐ Hives or Rash
☐ Unexplained Fever	☐ Emphysema	☐ Hepatitis A (Infectious)	☐ Drug Addiction/Alcoholism	☐ Need Premedication?
☐ Bruise Easily/Blood Disease	☐ Tuberculosis	☐ Hepatitis B or C	☐ Tattoos/Body Piercing	☐ Ever taken fen-phen?
☐ Anemia	☐ Cancer	☐ Protease Inhibitor	☐ Sleep Apnea	☐ Cochlear Implants?
☐ Coronary Stent*	☐ X-Ray Treatment (radiation)			

Have you ever had any other serious illness not checked above? Discuss: _____

Do you wish to talk to the dentist privately about any problem? ☐ 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:

X _____ Date: _____

Patient Signature (Parent or Guardian)