

PATIENT NAME _____ DATE _____
LAST FIRST M

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, or do your gums ever bleed? _____ YES NO
 Do you brush and floss on a routine basis? Discuss _____ YES NO
 Do you feel nervous about having dental treatment? _____ YES NO
 Do you want to keep your remaining teeth? _____ YES NO
 Do you have Mercury Silver filling in your mouth? _____ YES NO
 Do you like your smile? Why? _____ YES NO
 Name of previous dentist (optional) _____
 Whom may we thank for referring you to our office? _____

MEDICAL HISTORY ■

Medical doctor's name _____
 Are you under a doctor's care now? Why? _____ YES NO
 Have you been diagnosed with any medical problems (serious or otherwise)? _____ 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 | Fainting or Dizziness | Tuberculosis | Cancer | Alcoholism |
| High Blood Pressure | Stroke | Liver Disease | Thyroid Disease | Blood Transfusion |
| Low Blood Pressure | Diabetes | Hepatitis A (infect.) | Parathyroid Disease | Hemophilia |
| Heart Murmur | Excessive Thirst | Hepatitis B (serum) | Chemotherapy/Radiation | AIDS - HIV+ |
| Rheumatic Fever | Artificial Joints/Hips | Yellow Jaundice | Arthritis/Gout | Venereal Disease |
| Congenital Heart Lesion | Kidney Trouble | Chronic Headaches | Rheumatism | Cold Sores |
| Artificial Heart Valve | Ulcers | Chronic Neck Pain or Stiffness | Pain in Jaw Joints | Fever Blisters |
| Heart Pacemaker | Allergies | Ringling, Buzzing or Clogged Ears | Cortisone Medicine | Herpes |
| Heart Surgery | Asthma | Pain in Ears or Face | Glaucoma | Bruise Easily |
| Blood Disease | Hay Fever | Clicking or Grinding noises in your jaw joint | Epilepsy or Seizures | Sickle Cell Anemia |
| Anemia | Sinus Trouble | Stiffness / Locking of Jaw | Nervousness | Osteoporosis |
| Chest Pain | Emphysema | | Hypoglycemia | Mercury Fillings |
| Shortness of Breath | Frequent Cough | | Psychiatric Care | Transplant |
| Swelling of Feet/Ankles/Hands | Lung Disease | | Drug Addiction | |

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

Please describe in detail _____

List any surgeries _____ Date _____
 _____ Date _____

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by: Doctor _____ Date _____

MEDICAL UPDATES ■

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	NONE	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None <input type="checkbox"/>	_____	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	_____	DR. _____
_____	_____	None <input type="checkbox"/>	_____	_____	DR. _____