PATIENT NAME _____ **DATE** _____
LAST FIRST M.I.

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 examination 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 you 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
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 simile? Why? _____	YES NO
Name of previous dentist (optional) _____	YES NO

MEDICAL HISTORY

Medical doctor's name _____	YES NO
Are you under a doctor's care now? Why? _____	YES NO
Have you been hospitalized during the past two year? 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 CHECK THE FOLLOWING:

	YES	NO		YES	NO		YES	NO		YES	NO		YES	NO
Heart Trouble	☐	☐	Chest Pain	☐	☐	Scarlet Fever	☐	☐	Cancer	☐	☐	Hypoglycemia	☐	☐
High Blood Pressure	☐	☐	Shortness of Breath	☐	☐	Asthma	☐	☐	Thyroid Disease	☐	☐	Psychiatric Care	☐	☐
Low Blood Pressure	☐	☐	Swelling of Feet/			Hay Fever	☐	☐	Abnormal Bleeding	☐	☐	Drug Addiction	☐	☐
Heart Murmur	☐	☐	Ankles/Hands	☐	☐	Sinus Trouble	☐	☐	Parathyroid Disease	☐	☐	Blood Transfusion	☐	☐
Rheumatic Fever	☐	☐	Fainting or Dizziness	☐	☐	Emphysema	☐	☐	X-ray or Cobalt Tmt.	☐	☐	Hemophilia	☐	☐
Congenital Heart Lesion	☐	☐	Stroke	☐	☐	Frequent Cough	☐	☐	Chemotherapy/Radiation	☐	☐	AIDS	☐	☐
Artificial Heart Valve	☐	☐	Diabetes	☐	☐	Lung Disease	☐	☐	Arthritis/Gout	☐	☐	Venereal Disease	☐	☐
Heart Pacemaker	☐	☐	Excessive Thirst	☐	☐	Tuberculosis	☐	☐	Rheumatism	☐	☐	Cold Sores	☐	☐
Heart Surgery	☐	☐	Artificial Joints/Hips	☐	☐	Liver Disease	☐	☐	Pain in Jaw Joints	☐	☐	Fever Blisters	☐	☐
Blood Disease	☐	☐	Kidney Trouble	☐	☐	Hepatitis A (infec.)	☐	☐	Cortisone Medicine	☐	☐	Herpes	☐	☐
Anemia	☐	☐	Ulcers	☐	☐	Hepatitis B (serum)	☐	☐	Glaucoma	☐	☐	Bruise Easily	☐	☐
			Allergies	☐	☐	Yellow Jaundice	☐	☐	Epilepsy or Seizures	☐	☐	Sickle Cell Anemia	☐	☐
									Nervousness	☐	☐	HIV	☐	☐

Have you ever had any other serious illnesses not circled above? ☐ YES ☐ NO

Please describe in detail _____

Do you wish to talk to the doctor privately about any problem? ☐ YES ☐ NO

X _____
PATIENT SIGNATURE (PARENT OR GUARIAN)

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		PATIENT'S SIGNATURE	B.P.		REVIEWED BY
_____	_____	None ☐	_____	_____	DR.	_____
_____	_____	None ☐	_____	_____	DR.	_____
_____	_____	None ☐	_____	_____	DR.	_____
_____	_____	None ☐	_____	_____	DR.	_____
_____	_____	None ☐	_____	_____	DR.	_____
_____	_____	None ☐	_____	_____	DR.	_____
_____	_____	None ☐	_____	_____	DR.	_____

ACCOUNT NUMBER

INITIAL DENTAL AND MEDICAL HISTORIES & UPDATES