PATIENT NAME ____

DENTAL HISTORY

YES No

☐ ☐ Do you have a specific dental problem? Describe ______________________________
☐ ☐ Do you have dental examinations on a routine basis? Last visit ______________________________
☐ ☐ Do you have a specific dental problem? Discuss ______________________________
☐ ☐ Do your gums ever bleed? Discuss ______________________________
☐ ☐ Do you have sensitivity in your teeth? Discuss ______________________________
☐ ☐ Does food catch between your teeth? Any loose teeth? ______________________________
☐ ☐ Do you ever have clicking, popping or discomfort in the joint? ______________________________
☐ ☐ Do you grind your teeth? ______________________________
Are you happy with your smile? Discuss ______________________________
☐ ☐ Any sores or growths in your mouth? Discuss ______________________________
Name of previous dentist (optional) ______________________________

MEDICAL HISTORY

YES No

☐ ☐ Are you under a physician's care now? Why? ______________ DR's name______________ Phone ____________
☐ ☐ 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? Discuss ______________________________
☐ ☐ Are you allergic to any medications or substances? Please check box below:
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal (nickel, mercury, etc) ☐ Latex/Rubber ☐ Other____________

Do you now have or have you ever had any of the following? Please check appropriate boxes.

YES	No		YES	No		YES	No		YES	No	
☐	☐	Heart Murmur	☐	☐	Lung disease	☐	☐	Diabetes	☐	☐	Cold Sores
☐	☐	Heart Attack/failure	☐	☐	Breathing Problem	☐	☐	Hypoglycemia	☐	☐	Herpes
☐	☐	Chest Pain/Angina	☐	☐	Shortness of Breath	☐	☐	Liver Disease	☐	☐	Stroke
☐	☐	Mitral Valve Prolapse	☐	☐	Frequent Cough	☐	☐	Hepatitis	☐	☐	Convulsions
☐	☐	Scarlet Fever	☐	☐	Hay Fever	☐	☐	Kidney Problems	☐	☐	Epilepsy or Seizers
☐	☐	Rheumatic fever	☐	☐	Sinus Trouble	☐	☐	Thyroid Disease	☐	☐	Fainting or Dizziness
☐	☐	Artificial Heart Valve	☐	☐	Asthma	☐	☐	Arthritis/Gout	☐	☐	Glaucoma
☐	☐	High Blood Pressure	☐	☐	Bloody Sputum	☐	☐	Rheumatism	☐	☐	Nervousness
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Cortisone Medicine	☐	☐	Psychiatric Care
☐	☐	Blood Disease	☐	☐	Tuberculosis	☐	☐	Back Problem	☐	☐	Alzheimer's Disease
☐	☐	Bruise Easily	☐	☐	Cancer	☐	☐	Artificial Joint	☐	☐	Allergies (Pollen/Dust)
☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐	Venereal Disease	☐	☐	Hives or Rash
☐	☐	Sickle Cell Disease	☐	☐	Chemotherapy	☐	☐	AIDS	☐	☐	Need Premedication ?
☐	☐	Bleeding Problem	☐	☐	Stomach/Intestinal Disease	☐	☐	HIV Positive	☐	☐	Eating Disorder
☐	☐	Leukemia	☐	☐	Ulcers	☐	☐	Genital Herpes	☐	☐	Cigarette Smoking
☐	☐	Recent Blood Transfusion	☐	☐	Recent Weight Loss	☐	☐	Drug Addiction/Alcoholism			

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

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.

____
PATIENT SIGNATURE (PARENT OR GUARDIAN) DATE

Reviewed By Doctor ______________________________

History Review and Significant Findings ______________________________

____

MEDICAL UPDAES

I have read my Medical History and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	BP	REVIEWED BY

DENTAL AND MEDICAL HISTORIES- UPDATES