PATIENT NAME ____ DATE ______________
DATE OF BIRTH ____________________

Primary reason for this dental appointment: ______ Exam ______ Emergency ______ Consultation

DENTAL HISTORY

Please indicate Yes or No:

Yes	No	1.	Do you have a dental problem?
			If yes, please describe: ____
Yes	No	2.	Do you receive routine dental care?
			Last visit ___________________________
			Treatment received ____________________________________
			Last cleaning _________________________
			Last x-rays ___________________________
Yes	No	3.	Are you aware of any growths or sores in your mouth?
Yes	No	4.	Do your gums bleed?
		5.	How frequently do you brush? _____________________________________
		6.	How frequently do you floss? ______________________________________
Yes	No	7.	Are you happy with the appearance of your teeth?
Yes	No	8.	Does food catch between your teeth?
Yes	No	9.	Do you have any loose teeth?
Yes	No	10.	Do you have frequent earaches or headaches?
Yes	No	11.	Have you lost any teeth?
			If yes, please describe why: ____
Yes	No	12.	Have you ever had any problems or complications with your dental care in the past?
			Please explain: ____
Yes	No	13.	Does your mouth feel dry?
Yes	No	14.	Do you often consume: _____ Candy/mints/gum _____ Soda pop _____ Coffee/tea _____ Cough drops
Yes	No	15.	Do you have trouble chewing any types of food?
Yes	No	16.	Do you smoke or chew tobacco?
Yes	No	17.	Do you have any other questions or concerns about dentistry or your dental health?
			If yes, please describe: ____

Comments: ____
____

MEDICAL HISTORY

Date of your last physical exam: ____________________
What is your impression of your present health? ___________________________________

Please indicate Yes or No:

Yes	No	1.	Has there been any change in your general health within the last year?
Yes	No	2.	Are you presently, or have you been in the last year, under the care of a physician?
Yes	No	3.	Have you had any serious illness, operation, or been hospitalized within the last 5 years?
Yes	No	4.	Are you taking any medication including non-prescription drugs?
			If yes, please list: ____
			____
Yes	No	5.	Have you taken or are you now taking steroids?
Yes	No	6.	Do you have or have you had a problem with alcohol or drug abuse?
Yes	No	7.	Do you use or have you used tobacco products?
Yes	No	8.	Are you pregnant? (Women only)
Yes	No	9.	Do you take birth control pills (Women only)

-CONTINUED-

Are you allergic or have you had a reaction (swelling, rash, itching) to:

_____ Penicillin

_____ Local Anesthetics (numbing agents)

_____ Other drugs/medications ___________________________

_____ Latex/rubber products

_____ Metals/jewelry

_____ Other ______________________________________

Have you now, or have you in the past, had any of the following?
Please check all that apply:

_____ Artificial joints/Joint Replacements

_____ Heart trouble/Surgery

_____ Chest pain

_____ Rheumatic fever

_____ Heart Murmur

_____ Irregular heart beat

_____ Mitral valve prolapse

_____ Sudden weight loss/gain

_____ Stroke

_____ Shortness of breath

_____ Herpes

_____ Leukemia

_____ Persistent cough

_____ Sinus problems

_____ Malignant Hyperthermia/ Family History

_____ Jaundice or other liver problems

_____ Diabetes/Family history

_____ Thyroid problems

_____Kidney/bladder problems

_____ Cancer or tumor

_____ Scalp or skin disease

_____ High blood pressure

_____ Venereal disease

_____ Syphilis/Gonorrhea

_____ Emphysema

_____ Anemia/Blood diseases

_____ Arthritis or painful joints

_____ Lumps/Swollen glands in neck or armpit

_____ Sickle cell disease

_____Emotional problems

_____ Abnormal prolonged bleeding

_____ Indwelling catheter/shunt

_____ Hepatitis

_____ Pacemaker

_____ AIDS or HIV infection

_____ Stomach or intestinal problems

_____ Hay fever/asthma

_____ Convulsions/seizures/fainting

_____ Tuberculosis

_____ Eye problems/glaucoma

Please list any diseases, conditions, or problems you have not listed above ____
____

I certify that, to the best of my knowledge, the above information is complete and accurate. If there are any changes in my health or medicines, I will inform the doctor at my next appointment.

Signature ____ Date _________________________