

PATIENT NAME: _____ DATE: _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History Please Circle

Do you have a specific dental problem? _____ Yes No
Do you have dental examinations on a routine basis? Date of Last Visit: _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss: _____ Yes No
Do your gums ever bleed? Discuss: _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose 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 experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss: _____ Yes No
Date of last full mouth x-rays (16 small films or panoramic): _____ Yes No
Name of previous dentist (optional): _____ Yes No

Medical History Please Circle

Are you under a physician's care now? Why? _____ Who? _____ Phone: _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss: _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss: _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Do you use a CPAP? _____ Yes No
Do you snore? _____ Yes No
Have you been diagnosed with Sleep Apnea? _____ Yes No

Are you allergic to any medications or substances? Please check boxes below:
 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 medications? Please check appropriate boxes below.
**If yes to any of the starred conditions, please call prior to your appointment. Premedication or changes in medication may be required.*

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
| Heart Disease/Surgery* | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Fosamax, Actonel, Boniva | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Medicine | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur or Defect* | <input type="checkbox"/> | <input type="checkbox"/> | Methemoglobinemia | <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Intestinal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular Heart Beat | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina/Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Recent Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack/Failure | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of Limbs | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Heart Disorder* | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse* | <input type="checkbox"/> | <input type="checkbox"/> | Breathing Problem | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever* | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Cough | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial Heart Valve* | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A (Infectious) | <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Pace Maker* | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B or C | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Pulmonary Shunt* | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Protease Inhibitor | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Night Sweats | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> |
| Bacterial Endocarditis* | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatments | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Unexplained Fever | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Renal Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | Allergies (Medicines) | <input type="checkbox"/> | <input type="checkbox"/> |
| Bruise Easily/Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | Allergies (Pollen/Dust) | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Bisphosphonates | <input type="checkbox"/> | <input type="checkbox"/> | Parathyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | Need premedication? | <input type="checkbox"/> | <input type="checkbox"/> |
| Coronary Stent* | <input type="checkbox"/> | <input type="checkbox"/> | Osteonecrosis of Jaw | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/Gout | <input type="checkbox"/> | <input type="checkbox"/> | Ever taken fen-phen? | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Aredia I.V. Reclast I.V. | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | Cochlear Implants | <input type="checkbox"/> | <input type="checkbox"/> |
| Sickle Cell Disease | <input type="checkbox"/> | <input type="checkbox"/> | Zometa I.V. | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Have you ever had any other serious illness not checked above? Discuss: _____ Yes No
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 without fail.

X _____ Date: _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor: _____ Date: _____ BP: _____ Pulse: _____

History Review and Significant Findings: _____