DENTAL AND MEDICAL HISTORIES - UPDATES

Date_____ **Patient Name**_____

Reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

(Please circle yes or no for the following)

DENTAL HISTORY

Do you have a specific dental problem? Yes / No Describe:_____

Do you have dental examinations on a routine basis? Yes / No Last visit:_____

Do you think you have active decay or gum disease? Yes / No _____

Do you brush and floss on a routine basis? Yes / No Discuss:_____

Do your gums ever bleed? Yes / No Discuss:_____

Do you like your smile? Yes / No Why?_____

Do you want to keep your remaining teeth? Yes / No _____

Do you ever have clicking, popping, or discomfort in the jaw joint? Yes / No 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 tobacco? Yes / No Any sores or growths in your mouth? Yes / No Describe:_____

Name of previous dentist (optional):_____

Date of last full-mouth x-rays (16 small films or panoramic):_____

(Please circle yes or no for the following)

MEDICAL HISTORY

Are you under a physician's care now? Yes / No Why?_____ Who?_____ Phone_____

Have you ever been hospitalized or had a major operation? Yes / No Describe:_____

Have you ever had a serious injury to your head or neck? Yes / No Describe:_____

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? Yes / No Please list:_____

_____

Are you on a special diet? Yes / No Describe:_____

Are you allergic to any medications or substances? Yes / No Please check box below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ 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? Please check appropriate boxes.

If yes to any of the starred conditions, please call prior to your appointment—premedication may be required.

Y	N		Y	N		Y	N		Y	N		Y	N	
☐	☐	Heart Disease/Surgery*	☐	☐	Bruise Easily/ Blood Disease	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Night Sweats	☐	☐	Cold Sores
☐	☐	Heart Murmur*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters
☐	☐	Irregular Heart Beat	☐	☐	Sickle Cell Disease	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes
☐	☐	Angina/Chest Pain	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Aredia I.V.	☐	☐	Renal Dialysis	☐	☐	Stroke
☐	☐	Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Zometa I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions
☐	☐	Congenital Heart Disorder	☐	☐	Recent Blood Transfusion	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures
☐	☐	Mitral Valve Prolapse*	☐	☐	Swelling of Limbs	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness
☐	☐	Scarlet Fever	☐	☐	Lung Disease	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Glaucoma
☐	☐	Rheumatic Fever*	☐	☐	Breathing Problem	☐	☐	Recent Weight Loss	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths
☐	☐	Artificial Heart Valve*	☐	☐	Shortness of Breath	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Nervousness
☐	☐	Heart Pace Maker*	☐	☐	Frequent Cough	☐	☐	Diabetes	☐	☐	Artificial Joint*	☐	☐	Psychiatric Care
☐	☐	Pulmonary Shunt	☐	☐	Hay Fever	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐	Alzheimer's Disease
☐	☐	High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Allergies (Medicines)
☐	☐	Low Blood Pressure	☐	☐	Asthma	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Allergies (Pollen/Dust)
☐	☐	Bacterial Endocarditis	☐	☐	Cancer	☐	☐	Hepatitis A (Infectious)	☐	☐	Genital Herpes	☐	☐	Hives or Rash
☐	☐	Unexplained Fever				☐	☐	Hepatitis B or C	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?*
☐	☐	Anemia							☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*

Have you ever had any other serious illness not checked above? Yes / No Describe:_____

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.

Patient Signature (Parent or Guardian)_____ Date_____

Reviewed By Doctor_____ Date_____ BP_____ Pulse_____

History Review and Significant Findings_____

_____

MEDICAL UPDATES

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

Date	Exceptions		Patient's Signature	BP	Pulse	Reviewed by:
_____	_____	☐ None	_____	_____	_____	Dr. _____
_____	_____	☐ None	_____	_____	_____	Dr. _____
_____	_____	☐ None	_____	_____	_____	Dr. _____
_____	_____	☐ None	_____	_____	_____	Dr. _____
_____	_____	☐ None	_____	_____	_____	Dr. _____
_____	_____	☐ None	_____	_____	_____	Dr. _____