PATIENT NAME _____ **DATE** _____

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? How often? _____ Yes No
Do your gums ever bleed? Explain _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you grind? _____ Yes No
Have you had any unpleasant dental experiences? Explain _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Explain _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (18 small films or panoramic): _____ Last dental visit _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____
Have you ever been hospitalized or had a major operation? Explain _____ Yes No
Have you ever had a serious head or neck injury? Explain _____ Yes No
Are you taking any medications, pills or drugs? Explain? _____ Yes No
Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) What? _____ Yes No
Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? Explain _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____
Women (please check): ☐ Pregnant/ trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives. Explain _____ Yes No
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...pre-medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No
Daily Aspirin	☐	☐	Excessive Bleeding	☐	☐	Ulcers	☐	☐	Drug Addiction/Alcoholism	☐	☐
Irregular Heart Beat	☐	☐	Sickle Cell Disease	☐	☐	Diabetes	☐	☐	Sleep Apnea	☐	☐
Angina/Chest Pain	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Excessive Thirst	☐	☐	Cold Sores	☐	☐
Heart Attack/Failure	☐	☐	Leukemia	☐	☐	Hypoglycemia	☐	☐	Herpes	☐	☐
Congenital Heart Disorder	☐	☐	Recent Blood Transfusion	☐	☐	Liver Disease	☐	☐	Convulsions	☐	☐
Artificial Joints*	☐	☐	Breathing Problems/Shortness of Breath	☐	☐	Hepatitis B or C	☐	☐	Epilepsy or Seizures	☐	☐
Artificial Heart Valve*	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Fainting or Dizziness	☐	☐
Heart Pace Maker	☐	☐	Hay Fever	☐	☐	Renal Dialysis*	☐	☐	Glaucoma	☐	☐
Heart Surgery	☐	☐	Sinus Trouble	☐	☐	Organ transplant*	☐	☐	Tumors or Growths	☐	☐
High/Low Blood Pressure	☐	☐	Asthma	☐	☐	Thyroid Disease	☐	☐	Nervousness/Anxiety	☐	☐
Blood Disease	☐	☐	Emphysema	☐	☐	Parathyroid Disease	☐	☐	Psychiatric Care	☐	☐
Leukemia	☐	☐	Tuberculosis	☐	☐	Arthritis/Gout	☐	☐	Alzheimer's Disease	☐	☐
Bruise Easily	☐	☐	Cancer	☐	☐	Rheumatism	☐	☐	Allergies to Enviroment	☐	☐
Anemia	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Pain in Jaw Joints	☐	☐	Hives or Rash	☐	☐
Chemotherapy*	☐	☐	Stomach/Intestinal Disease	☐	☐	AIDS/HIV Postivie	☐	☐	Need Pre-medication	☐	☐

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

Medical Updates

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

Medical/Dental History

MED. ALERT