Patient Name _____ **Date** _____

Primary Reason for this Appointment ☐ EXAMINATION ☐ EMERGENCY ☐ CONSULTATION ☐ CLEANING

REFERRED BY _____

DENTAL HISTORY

Do you have a specific dental problem? Describe _____ ☐ YES ☐ NO
Do you have dental examinations on a routine basis? Last Visit _____ ☐ YES ☐ NO
Do you brush and floss on a routine basis? Describe _____ ☐ YES ☐ NO
Do your gums bleed? Describe _____ ☐ YES ☐ NO
Do you smoke or chew? ☐ YES ☐ NO Any sores in your mouth? ☐ YES ☐ NO
Date of last X-rays (small films or panoramic) _____

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ ☐ YES ☐ NO
Are you taking any medications, pills or drugs? Why? _____ ☐ YES ☐ NO

_____

_____

Are you allergic to any medications or subtances? ☐ OTHER _____

☐ LATEX ☐ ANESTHETICS ☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ METAL ☐ ACRYLIC

Women (please check) ☐ pregnant/trying to get pregnant ☐ Nursing Discuss _____

PAST HEALTH HISTORY * Please check all that apply

☐ Heart Trouble/Disease	☐ Breathing Problems	☐ Tuberculosis	☐ Joint Replacements
☐ High Blood Pressure	☐ Sinus Trouble	☐ Rheumatic Fever	☐ Need Pre-Medication
☐ Low Blood Pressure	☐ Asthma	☐ Typhoid Fever	☐ Nervous Problems
☐ Circulatory Problems	☐ Arthritis	☐ Scarlet Fever	☐ Alzheimer's Disease
☐ Congenital Heart Disorder	☐ Mumps	☐ Diabetes	☐ Venereal Disease
☐ Hemophilia (Bleeding Problem)	☐ Measles	☐ Stroke	☐ Genital Herpes
☐ Irregular Heart Beat	☐ Tonsilitis	☐ Cancer	☐ Cold Sores/Fever Blisters
☐ Angina/Chest Pain	☐ Hepatitis	☐ Psychiatiric Care	☐ AIDS/HIV

Have you ever had any other serious illness not checked above? ☐ YES ☐ NO Discuss _____

_____

Do you wish to talk to the dentist privately about any problem? _____

To the best of my knowledge, all the proceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

Reviewed by Doctor _____ Date _____

PERSON TO CONTACT IN CASE OF EMERGENCY (OUTSIDE OF IMMEDIATE FAMILY HOUSEHOLD)

Name _____ Phone# _____

Address _____

MEDICAL UPDATES

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

Date	Exceptions or Changes	Patient's Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____