

PATIENT NAME _____ DATE _____

Primary Reason for this Dental Visit: Examination Emergency Consultation

DENTAL HISTORY What may we do for you? _____

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

Name of previous dentist (optional) _____

Do your gums ever bleed? _____ Yes No

If you could change anything about your teeth/smile, what would you change? _____

What would you like your teeth to be like in twenty years? _____

Do you ever have clicking, popping, or discomfort in the jaw? Yes No Do you grind your teeth? Yes No

Do you have any sores or growths in your mouth? Yes No Do you use tobacco? Yes No

MEDICAL HISTORY Are you under a physician's care now? Yes No Who? _____

Physician Phone _____ Why? _____

What special accommodations may we provide for you? _____

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

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

Are you taking any medications, pills, or drugs? What? _____ Yes No

Are you on a special diet? _____ Yes No

Are you allergic to any medication? Please check box below:

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____ Yes No

WOMEN (please check): Pregnant Taking Oral Contraceptive _____ Yes No

Have you had, or are you currently experiencing, any of the following? Circle/Check any that apply.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV | <input type="checkbox"/> Recent Blood Transfusion |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Cancer/Radiation/Chemotherapy | <input type="checkbox"/> Bruise Easily/Anemia | <input type="checkbox"/> Allergies (Pollen/Dust) |
| <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental/Emotional Impairment |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sickle Cell Disease | |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Hemophilia(Bleeding Problem) | |

Have you ever had any serious illness not checked above? Yes No Discuss _____

Emergency Contact _____ Phone _____

To the best of my knowledge, all the preceding answers are correct.

X _____ Date _____
Patient Signature (parent or guardian)

Reviewed by Provider _____ Date _____

History View and Significant Findings _____

Please report any changes to your medical history, including change in medication, to our staff at your next appointment.