Your Dental History

Patient Name ____________________ **Date** ____________

Primary reason for appointment today: □ Exam/Cleaning □ Consultation □ Emergency □ Other

Former Dentist ____________________ City, State ____________

Date of last dental visit____________________

Please tell us what you liked about your last dental experience____________________

____

Please tell us what you did not like about your last dental experience ____________________

____

How often do you brush & floss? ____________________

Do You: □ Smoke □ Chew Tobacco □ Bite Nails □ Grind Teeth

Your Medical History

Primary Care Physician Name/Telephone #____________________

Are you under the care of any other physicians? If so, please list name/telephone # ____________________

____

Your current physical health is: □ Excellent □ Good □ Fair □ Poor

Have you ever had a serious injury/major operation? Discuss ____________________

Please list all medications/drugs you currently take (use back of this page for additional space)

____

Are you allergic to any of the following? Please check below:

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex Rubber □ Other (see next question)

Please list any other allergies to medications/drugs you may have____________________

Do you require pre-medication before dental visits?____________________

Women **(please check all that apply):** □ Pregnant/Trying □ Nursing □Taking Oral Contraceptives

Do you now have, or have you ever had any of the following? Please check appropriate boxes below

□ Heart Trouble/Disease	□ Anemia	□ Cancer	□ Artificial Joint
□ Mitral Valve Prolapse	□ Blood Disease	□ Radiation	□ Herpes/Cold Sores
□ Heart Murmur	□ Heart Surgery	□ Chemotherapy	□ Venereal Disease
□ Artificial Heart Valve	□ Hemophilia	□ Stomach/Intestinal Problems	□ HIV/AIDS
□ Rheumatic Fever	□ Sickle Cell Disease	□ Diabetes	□ Stroke
□ Heart Attack/Failure	□ Leukemia	□ Hepatitis/Liver Disease	□ Convulsions
□ Congenital Heart Disorder	□ Lung Disease	□ Kidney Problems/Dialysis	□ Epilepsy or Seizures
□ Irregular Heart Beat	□ Breathing Problems	□ Thyroid Disease	□ Glaucoma
□ Heart Pace Maker	□ Asthma	□ Parathyroid Disease	□ Tumors
□ High Blood Pressure	□ Emphysema	□ Arthritis/Gout	□ Hives or Rash
□ Low Blood Pressure	□ Tuberculosis	□ Rheumatism	□ Allergies
		□ Drug Addiction/Alcoholism	□ Psychiatric Care

Please indicate if you have any serious illnesses not listed above ____________________

Do you wish to speak to the dentist about any problems? ____________________

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**____________

Medical Updates on backside of this page

Medications

Drug Name	Treatment for	Dosage

Medical History Updates

Date	Changes	Patient's Signature	Reviewed by