PATIENT NAME ______________________________ Today's Date ____________

PATIENT NAME

DENTAL HISTORY

	Yes	No
1. Do you have a specific dental problem? Describe______________________	☐	☐
2. Do you think you have active decay or gum disease?______________________	☐	☐
3. Do you brush and floss on a routine basis?______________________	☐	☐
4. Do your gums ever bleed?______________________	☐	☐
5. Are your teeth sensitive to hot or cold liquids/foods?______________________	☐	☐
6. Are your teeth sensitive to sweet or sour liquids/foods?______________________	☐	☐
7. Do you feel pain to any of your teeth?______________________	☐	☐
8. Do you ever have clicking, popping, or discomfort in the jaw joint?______________________	☐	☐
9. Do you clench or grind your teeth?______________________	☐	☐
10. Do you bite your lips or cheeks frequently?______________________	☐	☐
11. Have you had any orthodontic work?______________________	☐	☐
12. Have you ever had instruction on the correct method of brushing and flossing?______________________	☐	☐
13. Would you like to change anything about your smile? ______________________	☐	☐

14. Date of last full mouth X-rays ________________ Previous dental visit________________

15. Previous dentist ________________ Phone number of previous dentist ________________

MEDICAL HISTORY

	Yes	No
16. Are you under medical treatment? Why?______________________ Physician Phone	☐	☐
17. Have you ever been hospitalized or had a major operation? Describe______________________	☐	☐
18. Have you ever had a serious injury to your head or neck? Describe______________________	☐	☐
19. Are you taking any medications, pills or drugs? What?______________________	☐	☐
20. Do you use tobacco?	☐	☐
21. Do you use alcohol, cocaine, or other drugs? Which?______________________	☐	☐

22. Women (Please check) ☐ Pregnant ☐ Nursing ☐ Taking birth control pills

23. Are you allergic to or have any reactions to the following?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Local Anesthetics	☐	☐	Penicillin	☐	☐	Sulfa	☐	☐	Latex
☐	☐	Aspirin	☐	☐	Codeine	☐	☐	Acrylic	☐	☐	Other ____________

24. Do you now have or have you ever had any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Murmur*	☐	☐	Heart Disease	☐	☐	Heart Attack	☐	☐	Angina/Chest Pain
☐	☐	Mitral Valve Prolapse*	☐	☐	High Blood Pressure	☐	☐	Heart Trouble	☐	☐	Stroke
☐	☐	Artificial Heart Valve*	☐	☐	Low Blood Pressure	☐	☐	Anemia	☐	☐	Excessive Bleeding
☐	☐	Joint Replacement*	☐	☐	Arthritis/Gout	☐	☐	Sickle Cell Disease	☐	☐	Hemophilia
☐	☐	Rheumatic Fever*	☐	☐	Rheumatism	☐	☐	Asthma	☐	☐	Respiratory Problems
☐	☐	Hepatitis	☐	☐	Tuberculosis	☐	☐	Glaucoma	☐	☐	Epilepsy/Convulsions
☐	☐	Cancer	☐	☐	Leukemia	☐	☐	Liver Disease	☐	☐	Emphysema
☐	☐	Diabetes	☐	☐	Jaundice	☐	☐	Kidney Diseases	☐	☐	Renal Dialysis
☐	☐	AIDS or HIV	☐	☐	Venereal Disease	☐	☐	Radiation Therapy	☐	☐	Thyroid Problem
☐	☐	Stomach Ulcers	☐	☐	Fainting/Dizziness	☐	☐	Pacemaker	☐	☐	Other____________

MEDICAL UPDATES

Date	Exceptions		Patient's Signature	Reviewed by
______	______________________	None ☐	__________	__________
______	______________________	None ☐	__________	__________
______	______________________	None ☐	__________	__________
______	______________________	None ☐	__________	__________
______	______________________	None ☐	__________	__________
______	______________________	None ☐	__________	__________

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X ____

Signature of Patient, Parent or Guardian Date Signature of Doctor Date