Name_____ Date_____

Primary reason for this appointment: ☐Examination ☐Emergency ☐Consultation

Dental History

1. Do you have a specific dental problem? ☐yes ☐no. If yes, please describe: _____
_____
2. Do you have dental examinations on a routine basis? ☐yes ☐no
If yes, when was your last visit?_____
3. Do you like the appearance of your smile? ☐yes ☐no
If not, please describe what you would like to change?_____
4. Do you have any clicking, popping or discomfort in your jaw joint? ☐yes ☐no
5. Do you grind your teeth or have any excessive wearing away of your teeth? ☐yes ☐no
6. Have your past experiences in the dental office been positive? ☐yes ☐no
If no, please describe? _____
7. Do you smoke or chew tobacco? ☐yes ☐no
If you smoke cigarettes, how many packs per day? _____
8. When were your last dental x-rays? _____

Medical History

1. Are you currently under the care of a physician? ☐yes ☐no
If yes, why? _____
2. What is your physician's name? _____ Phone # _____
3. Have you ever been hospitalized or had a major operation? ☐yes ☐no
If yes, please describe: _____
4. Have you ever had a serious injury to your head or neck? ☐yes ☐no
If yes, please describe: _____
5. **Are you taking any medications, pills or drugs?** ☐yes ☐no
If yes, what? _____
6. **Are you allergic to any medications or substances?** ☐yes ☐no
If yes, what? _____
7. *WOMEN*: ☐pregnant ☐trying to get pregnant ☐nursing ☐taking oral contraceptives
8. Do you have or have you had any of the following? **Please write the word "yes" or "no" in the box to right:**

Heart trouble/disease		Hemophilia		Kidney Disease	
Heart Murmur		Leukemia		Thyroid Disease	
Irregular Heart Beat		Blood Transfusion		Arthritis	
Angina/Chest Pain		Breathing Problem		Venereal Disease	
Heart Attack		Sinus Trouble		AIDS/HIV +	
Congenital Heart Disorder		Asthma		Drug Addiction	
Mitral Valve Prolapse		Emphysema		Herpes	
Rheumatic Fever		Tuberculosis		Stroke	
Artificial Heart Valve		Cancer		Epilepsy/Seizures	
Heart Pacemaker		Radiation Treatment		Fainting/Dizziness	
High Blood Pressure		Chemotherapy		Glaucoma	
Blood Disease		Stomach problems		Tumors/Growths	
Bruise Easily		Ulcers		Psychiatric Care	
Anemia		Diabetes		Alzheimer's Disease	
Excessive Bleeding		Hypoglycemia		Artificial Joints	
Sickle Cell Disease		Hepatitis		Hives or Rash	

Have you ever had any other serious illness or condition not mentioned above? ☐yes ☐no
If yes, what? _____

X _____ Date _____
Patient Signature

Reviewed By Doctor_____ Date_____