

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary reason for this dental appointment (circle): Exam Emergency Consultation**

**DENTAL HISTORY** Please circle

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 think you have active decay or gum disease? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Do you brush and floss on a routine basis? Discuss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Do your gums ever bleed? Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Does food catch between your teeth? Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Do you have any loose teeth? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Do you use tobacco products? Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Do you have any growths or sores in your mouth? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

**MEDICAL HISTORY**

Are you under a physician’s care now? Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you ever had a serious injury to your head or neck? What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Are you taking any medications, aspirin, vitamins, herbals, pills, or drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on a special diet? Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

Are you allergic to any medications or substances? Please check the box below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

**□**Aspirin **□**Penicillin **□**Codeine **□**Acrylic **□**Metal **□**Latex Rubber **□**Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women (please check) **□**Pregnant/trying **□**Nursing **□**Oral Contraceptives \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check the box of any medical conditions below that you have had or currently have.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Heart Disease/Surgery | Excessive Bleeding | Chemotherapy | Night Sweats | Cold Sores |
| Heart Defect | Sickle Cell Disease | Osteoporosis | Yellow Jaundice | Fever Blisters |
| Angina/Chest Pain | Hemophilia | Bisphosphonates | Kidney Problems | Herpes |
| Heart Attack | Methemoglobinemia | Osteonecrosis of Jaw | Renal Dialysis | Stroke |
| Congenital HeartDisorder | Leukemia | Aredia I.V. Reclast I.V. | Thyroid Disease | Convulsions |
| Mitral Valve Prolapse | Recent Blood Transfusion | Zometa I.V. | Parathyroid Disease | Epilepsy of Seizures |
| Scarlet Fever | Swelling of Limbs | Fosamax, Actonel,Boniva | Arthritis/Gout | Fainting or Dizziness |
| Rheumatic Fever | Lung Disease | Stomach/IntestinalDisease | Rheumatism | Glaucoma |
| Artifical Heart Valve | Breathing Problem | Ulcers | Pain in Jaw Joints | Tumors or Growths |
| Heart Pace Maker | Shortness of Breath | Recent Weight Loss | Cortisone Medicine | Nervousness |
| Pulmonary Shunt | Frequent Cough | Frequent Diarrhea | Artificial Joint | Psychiatric Care |
| High Blood Pressure | Sinus Trouble | Diabetes | STDs | Alzheimer’s Disease |
| Low Blood Pressure | Asthma | Excessive Thirst | AIDS | Hives or Rash |
| Bacterial Endocarditis | Bloody Sputum | Hypoglycemia | HIV Positive | Need premedication? |
| Unexplained Fever | Emphysema | Liver Disease | Genital Herpes | Ever taken Fen-phen? |
| Bruise Easily/Blood issue | Tuberculosis | Hepatitis A | Drug Addiction | Cochlear Implants |
| Anemia | COPD | Hepatitis B or C | Alcoholism |  |
| Coronary Stent | Cancer | Protease Inhibitor | Radiation Treatments |  |

Have you ever had any other serious illness not checked above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

*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.*

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BP: \_\_\_\_\_\_\_\_\_\_\_mm Hg HR: \_\_\_\_\_ bpm

Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_