Patient Name: _____ D.O.B. _____ Date _____
Please answer all questions to the best of your knowledge. If you have any questions please ask the dentist or staff.

Dental History

When was your last dental visit? _____ What treatment was completed? _____

Are you apprehensive about dental treatment?	Yes	No
Have you ever had problems with dental treatment?	Yes	No
Have you ever been diagnosed with periodontal (gum) disease?	Yes	No
Do your gums ever bleed when you brush and floss?	Yes	No
Do you currently have dental pain or discomfort?	Yes	No
Do you experience clicking, popping or discomfort in the jaw?	Yes	No
Do you experience headaches frequently?	Yes	No
Do you suffer from dry mouth?	Yes	No
Are your teeth sensitive to:		
Hot?	Yes	No
Cold?	Yes	No
Bite?	Yes	No
Are you interested in teeth whitening?	Yes	No

Are there any other dental conditions or concerns we should know about? _____

Medical History

Are you currently under the care of a physician?	Yes	No
If yes, Name of Physician? _____ Phone # _____		
Are you currently taking any medications?	Yes	No
If yes, please list _____		
Do you need premedication before dental treatment?	Yes	No
If yes, Why? _____		
Have you ever taken bisphosphonate drugs(Fosamax, Alendronate, Risedronate Boniva, Zometa)?	Yes	No
Have you ever had infective endocarditis?	Yes	No
Do you smoke or use tobacco products?	Yes	No

Women:

Are you pregnant or trying to get pregnant?	Yes	No
If yes, How many weeks? _____		
Are you currently nursing (breast feeding)?	Yes	No

Are you allergic to any of the following?

Acrylic	Yes No	Erythromycin	Yes No	Sedatives	Yes No
Bleach	Yes No	Latex	Yes No	Tetracycline	Yes No
Codeine	Yes No	Metal	Yes No	Tramadol	Yes No
Dental Anesthetics	Yes No	Penicillin	Yes No	**Other**:_____	

Do you have or have you had any of the following medical conditions?

AIDS/HIV Positive	Yes	No	Eating Disorder	Yes	No	Low Blood Pressure	Yes	No
Alcohol Abuse	Yes	No	Emphysema	Yes	No	Lung Disease	Yes	No
Anaphylaxis	Yes	No	Epilepsy/Seizures	Yes	No	Mitral Valve Prolapse	Yes	No
Anemia	Yes	No	Excessive Bleeding	Yes	No	Osteoporosis	Yes	No
Angina/Chest Pain	Yes	No	Excessive Thirst	Yes	No	Pain in Jaw Joints	Yes	No
Arthritis	Yes	No	Fainting/Dizziness	Yes	No	Psychiatric Problems	Yes	No
Artificial Heart Valve	Yes	No	Frequent Cough	Yes	No	Radiation Treatments	Yes	No
Artificial Joint	Yes	No	Frequent Diarrhea	Yes	No	Recent Weight Loss	Yes	No
Asthma	Yes	No	GE Reflux/Acid Reflux	Yes	No	Recent Weight Gain	Yes	No
Blood Disease	Yes	No	Glaucoma	Yes	No	Shingles	Yes	No
Blood Transfusions	Yes	No	Hay Fever	Yes	No	Sickle Cell Disease	Yes	No
Breathing Problems	Yes	No	Heart Attack/Failure	Yes	No	Sinus Trouble	Yes	No
Bruise Easily	Yes	No	Heart Murmur	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Heart Pace Maker	Yes	No	Surgery	Yes	No
Chemotherapy	Yes	No	Heart Disease/Trouble	Yes	No	Thyroid Problems	Yes	No
Chest Pain	Yes	No	Heart Surgery	Yes	No	Tuberculosis	Yes	No
Cholesterol	Yes	No	Hemophilia	Yes	No	Tumors or Growths	Yes	No
Cold Sores	Yes	No	Hepatitis C	Yes	No	Ulcers	Yes	No
COPD	Yes	No	High Blood Pressure	Yes	No	Varicella/Chicken Pox	Yes	No
Diabetes	Yes	No	Irregular Heartbeat	Yes	No	Venereal Disease	Yes	No
Drug Addiction	Yes	No	Kidney Problems	Yes	No			
Dry Mouth	Yes	No	Liver Disease	Yes	No			

Have you ever had any other serious illness not listed above Yes No

If yes, please explain _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

`

_____ _____

Signature of Patient, Parent, or Guardian Date

For Office Use Only

Reviewed by _____ _____ _____

Signature Date

I have read my medical history and confirm that it states past and present medical conditions

_____ _____

Signature Date

Updated on _____by _____

I have read my medical history and confirm that it states past and present medical conditions

_____ _____

Signature Date

Updated on _____by _____

I have read my medical history and confirm that it states past and present medical conditions

_____ _____

Signature Date

Updated on _____by _____

I have read my medical history and confirm that it states past and present medical conditions

_____ _____

Signature Date

Updated on _____by _____

I have read my medical history and confirm that it states past and present medical conditions

_____ _____

Signature Date

Updated on _____by _____