Dental History

Reason for today's visit **Exam** **Emergency** **Consultation** Are you in pain? **Y** **N** How long?________
List any dental concerns and discomforts ____
When was your last dental visit?____
Would you describe your dental health as good? Comments____
Do you have active decay or gum disease? __________Do your gums bleed? Describe ____________________
Do you brush and floss on a routine basis? How often?____
Have you ever had a bad experience in a dental office? Describe____

Have you ever had orthodontic treatment (Braces)?____ YES NO
Do you smoke or use any tobacco? ____ YES NO
Do you clench or grind your teeth during the day or night?____ YES NO
Do you experience excessive daytime sleepiness? Do you snore?____YES NO
Do you feel nervous about dental work? ____YES NO

Medical History

Medical doctor's name __________________________ Phone (   ) _________________________________
Are you under a doctor's care? Why?____
Have you been hospitalized in the last two years? Why? ____
Are you pregnant? (women) ____

Please list ALL Medications

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Are you allergic to any Medications or Substances?

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Please CIRCLE if you have or had any of the following:

Heart Trouble	Hay Fever	Blood disease
Shortness of Breath	Sinus Trouble	Cortisone Medicine
High Blood Pressure	Allergies	Bruise easily
Low Blood Pressure	Emphysema	Sickle cell anemia
Heart Murmur	Tuberculosis	Blood transfusion
High Cholesterol	Lung Disease	Kidney trouble
Mitral Valve Prolapse	Scarlet Fever	Ulcers
Heart Pacemaker	Thyroid Disease	Cold Sores/Fever Blisters
Congenital Heart Lesion	Hypoglycemia	Stroke
Artificial Heart Valve	Excessive Thirst	Yellow jaundice
Rheumatic Fever	Diabetes	Drug addiction
Swelling of Feet/Ankles	Hepatitis (other)	Psychiatric care
Heart Surgery	Hepatitis B (serum)	Nervousness
Anemia	Hepatitis A (infection)	Epilepsy or Seizures
Glaucoma	Cancer	Liver disease
Pain in jaw joint	X-ray or Cobalt TX	Herpes
Rheumatism	Chemotherapy	Migraine Headaches
Arthritis/ Gout	Radiation Therapy	FEN PHEN / REDUX (last taken______________)
Fainting/Dizziness	AIDS	Osteoporosis/Osteopenia
Frequent Fever	Venereal Disease	Artificial Joints/Hips
Asthma	Hemophilia	
Chest Pain	Parathyroid disease	

Have you ever had any serious illness **not** listed above? What? ____

(For office use only) **Medical Updates**

____________________ ____________________ ____________________ ____________________

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Reviewed by Doctor________________________________ Date__________________ B.P. ____________