PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

Do you have any specific dental problem? Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have routine dental cleaning and exams? Last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do your gums ever bleed? Discuss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever have clicking, popping or discomfort in the jaw joint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or chew?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any sores or growths in your mouth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Do you have a primary care physician? \_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized or had a major operation in the past year?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so please list :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications? Please list or provide a copy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your **allergic** to any medications or substances? \_\_\_\_\_ Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For **Women:** Pregnant ?\_\_\_\_ Trying to get pregnant?\_\_\_\_\_ Nursing?\_\_\_\_\_ Taking oral contraceptives?\_\_\_\_

**PLEASE GO OVER THIS LIST AND CHECK ONLY THOSE THAT PERTAIN TO YOU**

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| **Do you have ,or have you had, any of the following conditions?** | | | |
| * Heart Trouble * Heart Murmur * Irregular heart beat * Heart Attack * Angina Chest pain * Stroke * MVP * Heart Valve * Heart Pacemaker * Heart surgery * **High Blood Pressure** * Low Blood Pressure * **Blood Thinner** | * Blood disease * Blood Transfusion * Anemia * Bruise easily * Lung Disease * Breathing problems * Asthma * Tuberculosis * Frequent cough * Cancer * Radiation treatment * Chemotherapy * Intestinal disease * Ulcers * Arthritis * Gout | * Diabetes * Hypoglycemia * Liver Disease * **Hepatitis A,B,C** * Yellow Jaundice * AIDS * HIV positive * Kidney Disease * Renal Dialysis * Thyroid Disease * **Epilepsy/seizures** * Dizziness * **Osteoporosis** * Drug Addiction * Glaucoma | * Cold sores * Herpes * Tumors * Alzheimer’s * Dementia * Psychiatric Care * Allergies * Hives/Rash * **ARTIFICIAL JOINT** * \_\_\_\_\_\_\_year of replacement and is: * **Pre- Med Needed**   (antibiotic) |

**Have you ever had a serious illness not checked above?** Discuss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature (parent or guardian)

Reviewed by Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Office Use** |
| **Medical updates:**  **Date\_\_\_\_\_\_\_\_\_\_ Update\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BP \_\_\_\_\_\_\_\_\_\_\_\_**  **Date \_\_\_\_\_\_\_\_\_\_ Update \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |