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**

|  |
| --- |
| **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |