Patient Name_____ Date_____

Dental History

What is the purpose of your visit today? (Be specific)_____

Do you have any Dental complaints? ☐ Yes ☐ No What?_____

Date of your last dental care exam _____ Where? _____

Date of your last cleaning _____Where?_____

Date of your last full mouth x-ray? _____Where?_____

Do your gums bleed when you brush? ☐ Yes ☐ No Do your gums bleed on their own/ spontaneously? ☐ Yes ☐ No

Medical History

Are you under a physician's care now ☐ Yes ☐ No If yes, for what reason _____

Physician _____Address_____Phone_____

Have you been hospitalized in the past two years? ☐ Yes ☐ No If yes, explain_____

Do you bleed excessively when cut_____ Do you Smoke?_____If yes, how much?_____

Are you taking any medications, pills or drugs including over the counter or vitamins ? ☐ Yes ☐ No

IMPORTANT: If yes Please list all medications_____

Do you now have, or have you had any of the following?

	YES	NO
Heart Disease		
Heart Attack/Surgery		
Heart Murmur		
Artificial Heart Valve		
Heart Pacemaker		
High Blood Pressure		
Anemia		
Sickle Cell Disease		
Bruise Easily		
Rheumatic Fever		
Liver Disease		

	YES	NO
Arthritis		
Rheumatism		
Artificial Prosthesis		
Nervousness		
Epilepsy or Seizures		
Diabetes		
Stroke		
Ulcers		
Emphysema		
Asthma		
Tuberculosis		

	YES	NO
Kidney trouble		
Sinus Trouble		
Hepatitis A or B		
Chemotherapy/radiation		
Cancer or Tumor		
Drug Addiction		
A.I.D.S/HIV		
Cosmetic Surgery		
VD (Syphillis Gonorrhea)		
Seasonal Allergies		
Cold sores		

Are you allergic or have you reacted adversely to any of the below

	YES	NO
Penicillin		
Aspirin		
Latex		

	YES	NO
Sulfa Drugs		
Erythromycin		
Local Anesthetic (Novacaine)		

	YES	NO
Ibuprofen (Motrin/Advil)		
Nitrous Oxide		
Codeine		

May we request your health records if needed? ☐ Yes ☐ No

Are you pregnant at this time? ☐ Yes ☐ No If yes, how many months/weeks? _____

Is there any other medical or dental information you feel we should know about? _____

_____

This information is given by X_____ _____

SIGNATURE OF PATIENT DATE

This Medical History was reviewed by _____ _____

SIGNATURE OF DENTIST DATE