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PATIENT MEDICAL DENTAL HISTORY

Patient's Name: ____
Last First Middle

Nickname: ____________________ Date of Birth: ____________________ Age: __________

Home (Mailing) Address: ____
Street City State Zip

MEDICAL HISTORY

How long since your physician gave you a complete check-up? __________ Blood Pressure if known: __________

Physician's Name: ____

Physician's Address: ____

Are you under care of a physician now? __________ If so, for what reason? ____________________

Are you taking any medication now? __________ If so, what medicine? ____________________

Woman: Are you pregnant now? __________ If so, when is baby due? ____________________

Do you have or have you ever had, any of the following conditions? (Please circle those that pertain):

- Heart Disease
- Heart Murmur
- Rheumatic Fever
- Prolonged Bleeding
- Dizzy or Fainting Spells
- Asthma/Hay Fever
- Stomach/Intestinal Disease
- Circulatory Problems
- High or Low Blood Pressure
- Anemia
- Hepatitis
- Diabetes
- Venereal Disease
- AIDS/HIV
- Kidney Disease
- Liver Disease
- Tuberculosis
- Epilepsy/Convulsions
- Psychiatric Treatment
- Radiation Treatment
- Frequent Headaches

Allergies or Unusual Reactions to:

- Aspirin
- Penicillin (or any antibiotics)
- Codeine
- Dental Anesthetic (Novocaine)
- Any other allergies __________

Remarks, Explanations: ____

Any other serious illness or health problems not mentioned above? ____________________

Do you consider yourself in good health? ____________________

DENTAL HISTORY

What is your reaction to having dental treatment done? (a) Dread it (b) Worry about it (c) Don't mind it

How long since your last dental visit? __________ What was done?: ____________________

How often do you have your teeth cleaned? __________ Have you lost any teeth? __________

Were replacements made? __________ If not, was there a particular reason why? ____________________

Are you familiar with proper flossing and brushing techniques? __________ Do you use them? __________

Do you have concerns about your breath? __________ If yes, explain: ____________________

Have you had a complete set of dental x-rays taken (16-18 x-rays)? __________ If yes, when? ____________________

Has any dental treatment previously been recommended but not completed? __________ If so, what was recommended: ____________________

Have you been happy with your previous dental treatment? ____________________

If not, please explain ____________________

Previous dentist __________ City __________ Reason for change: ____________________

Do you have or have you ever hand, any of the following conditions? (Please circle those that pertain)

- Bleeding Gums
- Tender or Swollen Gums
- Loose Teeth
- Sensitive Teeth
- Burning Tongue
- Painful or Sore Areas in your mouth
- Sinus condition
- Any Injury to the Mouth
- Complicated Extractions

Have you had:

- Orthodontic Treatment (Straightening Teeth)
- Periodontal (Gum) Treatment
- Endodontic (Root Canal) Treatment
- Crown (Cap) or Bridge Treatment
- Denture Treatment
- Pain or Ringing in Ears
- Do you Clench or Grind Teeth (Either Day or Night)
- Any Unusual Dental Experiences

Are you aware of any particular dental problems? __________ Anything else about your medical or dental history we should know? __________

Remarks, Explanations: ____

Signed ____ Date ____________________
(If patient is minor guardian signature required) Month/Day/Year

CHECKUP EXAMINATION

Have there been any changes in your physical condition, medical/dental history, or mailing address since your last visit, or since you filled out the form on the reverse side? Please indicate changes or no changes -- sign and date below.

❑ Changes ______________________ ______________________ ❑ No changes Signature: ______________________ Date: ______________________ Month/Day/Year	❑ Changes ______________________ ______________________ ❑ No changes Signature: ______________________ Date: ______________________ Month/Day/Year
❑ Changes ______________________ ______________________ ❑ No changes Signature: ______________________ Date: ______________________ Month/Day/Year	❑ Changes ______________________ ______________________ ❑ No changes Signature: ______________________ Date: ______________________ Month/Day/Year
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