PATIENT NAME				DATE		·	
Primary reason for this dental appointment:	ion 🗌 Emerge	ncy		Consultation			
Dental History						Please	Circle
Do you have a specific dental problem? Describe						Yes	No
Do you have dental examinations on a routine basis? Last							No
Do you think you have active decay or gum disease?							No
Do you brush and floss on a routine basis? Discuss							No
Do your gums ever bleed? Discuss							No
Do you like your smile? Why?						Yes	No
Does food catch between your teeth? Any loose teeth?							No
Do you want to keep your remaining teeth?						Yes	No
Do you ever have clicking, popping or discomfort in the jaw	joint? Do you brux	or grin	d?			Yes	No
Have your past experiences in a dental office always been							No
Do you smoke or chew? Any sores or growths in your mout						Yes	No
Name of previous dentist (optional):				<u> </u>	_		
Date of last full mouth x-rays (16 small films or panoramic):					-		
Medical History							
Are you under a physician's care now? Why?		٧	Vho?	PI	hone	Yes	No
Have you ever been hospitalized or had a major operation?							No
Have you ever had a serious injury to your head or neck? E							No
Are you taking any medications, aspirin, vitamins, herbals,							No
Are you on a special diet? Discuss							No
Are you allergic to any medications or substances? Please	check box below					Yes	No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Mel	al Latex Rubb	er 🗆	Milk	Other			
Women (Please check): Pregnant/trying to get pregna							No
Do you now have or have you ever had any of the following							
*If yes to any of the starred conditions, please call prior to		preme				16.	
Yes No Yes Heart Disease/Surgery*	No Chemotherapy			No ☐ Night Sweats	Yes No ☐ ☐ Cold Scres		s No
Heart Murmur or Defect *	Osteoporosis			☐ Yellow Jaundice	☐ ☐ Fever Blisters		ם כ
Irregular Heart Beet 🔲 🔲 Hemophilia 🖂	☐ Bisphosphonate:			☐ Kidney Problems	☐ ☐ Herpes		
Angine/Cheet Pain	Osteonecrosis o			Renal Dialysis	☐ ☐ Stroke ☐ ☐ Convulsions		
Congenital Heart Disorder Recent Blood Transfusion	Aredia I.V. Reck	ast I.V.		☐ Thyroid Disease ☐ Parathyroid Disease	☐ ☐ Epilepsy or S		
Mitral Valve Prolapse * Swelling of Limbs	Economou Actor	el. Boniv		☐ Arthritis/Gout	☐ ☐ Fainting or Di	zziness 🗆	ם כ
Scarlet Fever	Stomach/intestin	al Disea	se 🗆	☐ Rheumatism	☐ ☐ Glaucoma		
Artificial Heart Valve "	Uncers			☐ Pain in Jaw Joints ☐ Cortisone Medicine	☐ ☐ Turnors or Gr		
Heart Pace Maker*	Recent Weight L		_	Artificial Joint *	☐ ☐ Psychiatric C		
Pulmonery Shunt*	Diabetes	JEA	ō	☐ Sexually Transmitted Disea	se 🔲 🔲 Alzheimer's 🛭		
Low Blood Pressure	Excessive Thirst			☐ AIDS	☐ ☐ Alfergies (Me		ם ב
Bacterial Endocarditis* 🔘 🗆 Bloody Soutum	Hypoglycemia			☐ HIV Positive ☐ Genital Herpes	☐ ☐ Allergies (Poli		
Unexplained Fever	Liver Disease Hepatitis A (Infe	ctious)	H	☐ Drug Addiction/Alcoholis			jö
Anemia	☐ Hepatitis B or C			☐ Tattoos/Body Piercing	Ever taken fer	n-phen?" 🗆) C
Coronary Sterit*	☐ Protease Inhibito			☐ Sleep Apnea	☐ ☐ Cochlear imp	lants?] [
Have you ever had any other serious illness not checked	above? Discuss					Yes	No
Do you wish to talk to the dentist privately about any prob		•				Yes	No
To the best of my knowledge, all the preceding answers are correct. If I have a	ny changes in my health	status or	if my	medicines change, I shall inform th	e dentist and staff at the nex		
X				Date_		••	—
•				_DateB	ь	tuloo	
Reviewed By Doctor						ulse	
History Review and Significant Findings							—
Minding Hadatan							
Medical Updates							
I have read my MEDICAL HISTORY dated		_ and	confi	rm that it adequately state	s past and present co	nditions.	
DATE EXCEPTIONS				PATIENT'S SIGNATURE B	P PULSE RE	VIEWED BY	
		None			Dr		
		None			Dr	•	
		None					
		None		-			
		None				·	
	,						300
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