PATIENT NAME _____ **DATE** _____

Primary reason for this appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe _____	Yes	No
Have you had dental examinations on a routine basis? Last visit _____	Yes	No
Do you think you have active decay or gum disease? _____	Yes	No
When do you routinely brush your teeth? _____ Do you routinely floss? _____	Yes	No
Do your gums ever bleed? _____	Yes	No
Do you like your smile? Why? _____	Yes	No
Does food catch between your teeth? Any loose teeth? _____	Yes	No
Do you want to keep your remaining teeth? _____	Yes	No
Do you ever have clicking, popping or discomfort in your jaw joints? _____	Yes	No
Do you brux, grind or clench your teeth? _____	Yes	No
Have your past experiences in a dental office always been positive? _____	Yes	No
Do you smoke or chew or vape tobacco? _____	Yes	No
Do you smoke or chew marijuana or use edible marijuana? _____	Yes	No
Do you have any sores or growths in your mouth? Discuss _____	Yes	No
Name of previous dentist (optional): _____		
Date of last full mouth x-rays (16 small films or panoramic) _____		

MEDICAL HISTORY

Are you under the care of a physician now? Who? _____ Why? _____	Yes	No
Have you been hospitalized or had a major operation? Discuss _____	Yes	No
Have you had a serious injury to your head or neck? Discuss _____	Yes	No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____	Yes	No
_____	Yes	No
Are you on a special diet? Discuss _____	Yes	No
Are you allergic to any medications or substances? Please check box below _____	Yes	No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk

☐ Other _____

Women (Please check): □ Pregnant/trying to get pregnant □ Nursing □ Taking oral contraceptives	Yes	No

Do you have or have you ever had any of the following? Do you take any off these medications? Please check the appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment. Premedication or changes in medication may be indicated.

	Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*			Asthma			Arthritis/Gout		
Heart Murmur of Defect*			Bloody Sputum			Rheumatism		
Irregular Heart Beat			Emphysema			Pain in Jaw Joints		
Angina/chest pain			Tuberculosis			Cortisone Medicine		
Congenital Heart Disorder			Cancer			Artificial Joint		
Mitral Valve Prolapse*			X-Ray Treatments(Radiation)			Sexually Transmitted Disease		
Scarlet Fever*			Chemotherapy			AIDS		
Rheumatic Fever*			Osteoporosis			HIV Positive		
Artificial Heart Valve*			Bisphosphonates			Using Cannabidiol or CBD		
Pulmonary Shunt*			Osteonecrosis of Jaw			Drug Addiction		
High Blood Pressure			Aredia I.V. Reclast I.V.			Tattoos/Body Piercing		
Low Blood Pressure			Zometa I.V.			Genital Herpes		
Bacterial Endocarditis			Fosamax, Actonel, Boniva			Sleep Apnea		
Unexplained Fever			Stomach/Intestinal Disease			Cold Sore		
Bruise Easily/Blood Disease			Ulcers			Fever Blisters		
Anemia			Recent Weight Loss			Herpes		
Coronary Stent*			Frequent Diarrhea			Stroke		
Excessive Bleeding			Diabetes			Convulsions		
Sickle Cell Disease			Excessive Thirst			Glaucoma		
Hemophilia			Hypoglycemia			Fainting or Dizziness		
Methemoglobinemia			Liver Disease			Epilepsy or Seizures		
Leukemia			Hepatitis A (Infectious)			Tumors or Growths		
Recent Blood Transfusion			Hepatitis B or C			Nervousness		
Swelling of Limbs			Protease Inhibitor			Psychiatric Care		
Lung Disease			Night Sweats			Alzheimer's Disease		
Breathing Problem			Yellow Jaundice			Allergies (Pollen/Dust)		
Shortness of Breath			Kidney Problems			Hives or Rash		
Frequent Cough			Renal Dialysis			Need Premedication?		
Hay Fever			Thyroid Disease			Ever Taken Fen-phen?*		
Sinus Trouble			Parathyroid Disease			Cochlear Implants?		

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 problem? _____ Yes No

X _____ Date _____
Patient signature (Parent or Guardian)

2019-10 EVZ