PATIENT NAME ______________________________ DATE ____________

DENTAL HISTORY

Have you been having any specific problems? ☐ Yes ☐ No Describe: ____________

Last dental visit? ____________ Purpose: ____________ Last complete exam: ____________

Has fear of discomfort kept you from regular visits? ☐ Yes ☐ No

How would you describe your present dental health? ☐ Good ☐ Fair ☐ Poor

Do you think you have active dental disease: Decay: ☐ Yes ☐ No Gum Disease: ☐ Yes ☐ No

Home care: Brush? ☐ Yes ☐ No Floss? ☐ Yes ☐ No Water Jet? ☐ Yes ☐ No Other: ____________

Do your gums ever bleed? ☐ Yes ☐ No How often? ____________ Are you troubled with bad breath? ☐ Yes ☐ No

How do you feel about ever losing your teeth? ____________

Have you had any unusual effects from previous dental treatment? ☐ Yes ☐ No Describe: ____________

MEDICAL HISTORY

Medical doctor's name: ____________ Last physical exam: ____________ (MONTH/DAY/YEAR) Doctor's Telephone: ____________

(Women) Are you pregnant? ☐ Yes ☐ No How long? ____________

Are you under a doctor's care now? ☐ Yes ☐ No If so, for what reason? ____________

Are you taking any medications, pills or drugs? ☐ Yes ☐ No Please List: ____________

Have you ever had any of the following?

☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Mononucleosis
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Prosthetic Joint
☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Psychiatric Treatment
☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Prolonged Bleeding
☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Herpes
☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	A.I.D.S./HIV
			☐ Yes	☐ No	Diabetes	☐ None of the above		

Have you ever had any other serious illness? ☐ Yes ☐ No Explain: ____________

Have you been hospitalized in the last two years? ☐ Yes ☐ No Why? ____________

Drug allergies: ☐ None ☐ Yes Please list: ____________

Do you wish to talk to the doctor about any problem not listed? ☐ Yes ☐ No

Comments: ____________

DATE: ____________ SIGNATURE: ____________

Reviewed by: Doctor ____________ Date ____________ Blood Pressure: ____________

I have read my MEDICAL HISTORY dated ____________ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	B.P.	REVIEWED BY
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.
		None ☐			DR.

DENTAL AND MEDICAL HISTORIES

C6