PATIENT NAME ______________________ LAST ______________________ FIRST ______ M DATE ______________

DENTAL HISTORY:

Do you have a specific dental problem? Describe ______________________

Do you have dental examinations on a routine basis? Last visit ______________________

Do you think you have active decay or gum disease? ______________________

Do your gums ever bleed? When? ______________________

Do you feel nervous about having dental treatment? ______________________

Have you ever had a bad experience in a dental office? Describe ______________________

Do you want to keep your remaining teeth? ______________________

Do you like the appearance of your teeth when you smile? ______________________

Name of previous dentist (optional) ______________________

MEDICAL HISTORY:

Medical doctor's name ______________________

Are you under a doctor's care now? Why? ______________________

Have you been hospitalized during the past two years? Why? ______________________

Are you taking any medications, pills, or drugs? What? ______________________

Are you allergic to any medications or substance? What? ______________________

Are you pregnant? (women) ______________________

Please CIRCLE if you have had any of the following:

AIDS (HIV positive)	Chronic Fatigue	Heart Murmur	Kidney or Liver Disease
Anemia	Diabetes	(Mitral Valve Prolapse)	Night Sweats
Asthma	Epilepsy	(Barlows Syndrome)	Rheumatic Fever
Blood Transfusion	Glaucoma	Hepatitis	Sinus Trouble
Cancer	Heart Trouble	High Blood Pressure	Tuberculosis
			Joint Replacement

Have you ever had any other serious illness not circled above? Please describe in detail ______________________

____

Do you wish to talk to the doctor privately about any problem? ______________________

X ______________________ Date ______________
PATIENT'S SIGNATURE (OR PARENT/GUARDIAN)

MEDICAL UPDATES:

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 - UPDATES