PATIENT NAME				DATE						
Primary reason for this	dental appointment: Exa	ımination	ency	□с	onsultation					
Dental History							f	Please	Circle	
	dental problem? Describe							Yes		
Do you have dental exa	aminations on a routine basis	? Last visit						Yes		
	active decay or gum disease'								No	
Do you brush and floss	on a routine basis? Discuss								No	
	ed? Discuss							Yes	No	
Do you like your smile?								Yes	No	
Does food catch between	en your teeth? Any loose tee	th?			··· - 17.0%			Yes	No	
Do you want to keep yo	our remaining teeth?							Yes	No	
Do you ever have clicki	ng, popping or discomfort in	the jaw joint? Do you l	orux or g	rind?_				Yes	No	
Have your past experie	nces in a dental office always	s been positive?			viv	-		Yes		
	? Any sores or growths in you							Yes	Nο	
Name of previous denti	st (optional):									
	c-rays (16 small films or pand	ramic):								
Medical History										
Are you under a physic	an's care now? Why?		٧	Vho?	Ph	one		Yes	No	
Have you ever been ho	spitalized or had a major ope	ration? Discuss						Yes		
Have you ever had a se	erious injury to your head or r	neck? Discuss						Yes	No	
Have you ever had a serious injury to your head or neck? Discuss							Yes	No		
Are you on a special di	et? Discuss			~~~				Yes	No	
Are you allergic to any	medications or substances?	Please check box belo	w					Yes	No	
Aspirin Penicilli	n 🗌 Codeine 🔲 Acrylic	☐ Metal ☐ Latex F	lubber	Oth	er					
	Pregnant/trying to get							Yes	No	
				-	•			103	140	
•	ave you ever had any of the fo	-								
	arred conditions, please call p		ent pre		• •					
Heart Trouble/Disease	Yes No Bruise Easily	Yes No ☐ ☐ Emphysema		Yes N	lo ☐ Yellow Jaundice	Yes No	oroc		s No	
Heart Murmur *	Anemia	☐ ☐ Emphysema ☐ ☐ Tuberculosis			Kidney Problems	Cold S				
Irregular Heart Beat	☐ Excessive Bleeding	☐ ☐ Cancer		ПГ	Renal Dialysis	Herpes				
Angina/Chest Pain Heart Attack/Failure	Sickle Cell Disease Hemophilia (Bleeding Problet	☐ X-Ray Treatment The control of the control	s (Radiation) 🗆 🗓	Thyroid Disease Parathyroid Disease	☐ ☐ Stroke				
	☐ ☐ Hemophilia (Bleeding Problet☐ ☐ Leukemia	m)	nal Diseas		Arthritis/Gout	Convul	sions sy or Seizures			
Mitral Valve Prolapse *	☐ ☐ Recent Blood Transfusion	☐ ☐ Ulcers		ПГ	¬ Rheumatism		g or Dizziness			
Scarlet Fever	Swelling of Limbs	Recent Weight	Loss		Pain in Jaw Joints	Glauco				
Rheumatic Fever* Artificial Heart Valve *	☐ ☐ Lung Disease ☐ ☐ Breathing Problem	Frequent Diarrh	ea		Cortisone Medicine Artificial Joint *	☐ ☐ Tumors	s or Growths			
Heart Pace Maker *	Shortness of Breath	Excessive Thirs	t		Venereal Disease	ш ш	atric Care			
Heart Surgery	Frequent Cough	☐ Hypoglycemia			¬ AIDS		ner's Disease			
High Blood Pressure Low Blood Pressure	☐ ☐ Hay Fever ☐ ☐ Sinus Trouble	Liver Disease Hepatitis A (Infe	octions)		☐ HIV Positive ☐ Genital Herpes		es (Medicines) es (Pollen / Dust)			
Blood Disease	Asthma	☐ ☐ Hepatitis B or C	,		☐ Drug Addiction/Alcoholisr	□ □ Allergion □ Hives				
Unexplained Fever	☐ ☐ Bloody Sputum	☐ ☐ Night Sweats			Tattoos	☐ ☐ Need				
Have you ever had any	other serious illness not che	cked above? Discuss						Yes	No	
To the hest of my knowledge a	ne dentist privately about any I the preceding answers are correct. If I	have any changes in my bear	th status or	if my ma	dicines change. I shall inform the	dentiet and staff at	the next annointm	Yes		
					-					
			-		Date				—	
PATIENT SIGNATURE (PAF	•									
	A STATE OF THE STA									
History Review and Signature	gnificant Findings									
Medical Updates										
I have read my MEDIC	AL HISTORY dated		and co	nfirm th	nat it adequately states p	ast and prese	nt conditions.			
DATE EXCEPTIONS	5				PATIENT'S SIGNATURE	BP	REVIEWED BY			
AND THE RESERVE OF THE PERSON			None				Dr			
			None				Dr			
***************************************	- Control of the Cont		None				Dr			
			None				Dr		***************************************	
			None			***************************************	Dr			
			None				Dr			
			None		,		Dr			