PATIENT NAME_____ DATE_____

LAST FIRST M

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

DENTAL HISTORY:

PLEASE CIRCLE

Do you have a specific dental problem/concern? Describe _____	YES	NO
Do you have dental examinations on a routine basis? Last visit _____	YES	NO
Would you describe your present dental health as good? Comments _____	YES	NO
Do you think you have active decay or gum disease? _____	YES	NO
Do your gums ever bleed? Discuss _____	YES	NO
Are you apprehensive about receiving any dental treatment? _____	YES	NO
Do you want to keep your remaining teeth?_____	YES	NO
Is there anything about your mouth, teeth, or smile you would like changed? _____	YES	NO
Have you needed or appreciated nitrous oxide (gas) analgesia with past dental treatment? _____	YES	NO
Do you feel you will need IV sedation or general anesthesia?_____	YES	NO
Have there been any complications during previous dental treatment? _____	YES	NO
Do you have difficulty opening your mouth? _____	YES	NO
Do you ever have clicking, popping, other noises, or discomfort from the jaw joints (TMJ)? Discuss _____	YES	NO
Does your jaw get "stuck", "locked", or "go out"? _____	YES	NO
Do you have pain in or about the ears or checks? _____	YES	NO
Do you have pain with chewing, yawning, or wide opening? _____	YES	NO
Does your bite feel uncomfortable or unusual? _____	YES	NO
Have you ever had an injury to your jaw, head, or neck? _____	YES	NO
Have you ever had arthritis? _____	YES	NO
Have you previously been treated for a Temporomandibular Joint Disorder? If so, when, what, how, and by whom?	YES	NO

_____

MEDICAL HISTORY:

Medical doctor's name _____ Phone _____

Are you under a doctor's care now? Why? _____	YES	NO
Have you been hospitalized during the past two years? Why? _____	YES	NO
Are you taking any medications, pills, or drugs? What? _____	YES	NO
Are you allergic to any medications or substance? What? _____	YES	NO
Women: Are you pregnant? _____	YES	NO

Please CIRCLE if you have had any of the following:

Heart Trouble	Shortness of Breath	Hay Fever	Parathyroid Disease	Drug Addiction
High Blood Pressure	Swelling of Feet/Ankles	Sinus Trouble	X-ray or Cobalt Tmt.	Blood Transfusion
Low Blood Pressure	Fainting or Dizziness	Emphysema	Chemotherapy/Radiation	Hemophilia
Heart Murmur	Stroke	Frequent Cough	Arthritis/Gout	AIDS, ARC
Rheumatic Fever	Diabetes	Lung Disease	Rheumatism	Venereal Disease
Congenital Heart Lesion	Excess Thirst	Tuberculosis	Pain in Jaw Joints	Cold Sores
Artificial Heart Valve	Artificial Joints/Hips	Liver Disease	Cortisone Medicine	Fever Blisters
Heart Pacemaker	Kidney Trouble	Hepatitis A (infec)	Glaucoma	Herpes
Heart Surgery	Ulcers	Hepatitis B (serum) Yellow	Epilepsy or Seizures	Bruise Easily
Blood Disease	Allergies (Pollen, etc)	Jaundice	Nervousness	Sickle Cell Anemia
Anemia	Scarlet Fever	Cancer	Hypoglycemia	Do you smoke?
Chest Pain	Asthma	Thyroid Disease	Psychiatric Care	Do you use alcohol?

Have you ever had any other serious illness not circled above?_____ YES NO

_____

Do you wish to talk to the doctor privately about any problem? _____ YES NO

_____ Date_____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

MEDICAL UPDATES:

DATE	CHANGES TO MEDICAL HISTORY/CURRENT CONDITIONS AND TREATMENTS	REVIEWED BY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____