

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Type of Patient: ( ) Orthodontic ( ) TMD ( ) Other: Explain \_\_\_\_\_

**Dental History**

**Please Circle**

Do you have a specific problem? 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

Do you brush and floss on a routine basis? \_\_\_\_\_ yes no

Do you feel nervous about having dental treatment? \_\_\_\_\_ yes no

Have you ever had a bad experience in a dental office? Describe \_\_\_\_\_ yes no

Do you like your smile? Why? \_\_\_\_\_ yes no

Have you had previous treatment by an orthodontist? \_\_\_\_\_ yes no

Name of general dentist \_\_\_\_\_

**Medical History**

Medical doctor's name and phone number \_\_\_\_\_

Are you under a physician's care now? Why? \_\_\_\_\_ yes no

Have you been hospitalized in the past two years? Why? \_\_\_\_\_ yes no

Are you taking any medications, pills, or drugs? Why? \_\_\_\_\_ yes no

Are you allergic to penicillin, codeine or any other medications? What? \_\_\_\_\_ yes no

If so describe any allergic reaction experienced \_\_\_\_\_

Are you pregnant? (women) \_\_\_\_\_ yes no

Do you smoke? \_\_\_\_\_ yes no

Does your jaw click or pop? \_\_\_\_\_ yes no

Do you have headaches on a regular basis? \_\_\_\_\_ yes no

Please Circle if you had any of the following:

- |                         |                        |                     |                     |                     |
|-------------------------|------------------------|---------------------|---------------------|---------------------|
| Heart Trouble           | Anemia                 | Ulcers              | Hepatitis B (serum) | Epilepsy or Seizure |
| High Blood Pressure     | Chest Pain             | Allergies           | Yellow Jaundice     | Hypoglycemia        |
| Heart Murmur            | Shortness of Breath    | Scarlet Fever       | Cancer              | Drug Addiction      |
| Rheumatic Fever         | Fainting or Dizziness  | Asthma              | X-ray or Cobalt Tmt | Hemophilia          |
| Congenital Heart Lesion | Stroke                 | Sinus Trouble       | Arthritis/Gout      | AIDS                |
| Artificial Heart Valve  | Diabetes               | Lung Disease        | Rheumatism          | Venereal Disease    |
| Heart Pacemaker         | Excessive Thirst       | Tuberculosis        | Pain in Jaw Joints  | Cold Sores          |
| Heart Surgery           | Artificial Joints/Hips | Liver Disease       | Cortisone Medicine  | Fever Blisters      |
| Blood Disease           | Kidney Trouble         | Hepatitis A (infec) | Glaucoma            | Herpes              |

Please list any other serious illness not circled above: \_\_\_\_\_

I understand that if any change occurs in my health I am to report it to the Dental Office as soon as possible. I have read and understand each question and have answered all of them truthfully and to the best of my ability. I will discuss my health history with my doctor.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature (Patient, Parent or Guardian)

Reviewed by Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Updates:** I have read my Dental and Medical History dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

Date	Exceptions	Signature	Reviewed By
_____	_____ ( ) None	_____	_____
_____	_____ ( ) None	_____	_____
_____	_____ ( ) None	_____	_____
_____	_____ ( ) None	_____	_____