PATIENT NAME_____ DATE_____

What is your primary reason for this dental appointment today? ☐ Examination ☐ Emergency ☐ Consultation

What level of dental care are you seeking at this time? ☐ Just get me out of pain ☐ Good enough to get by for now ☐ Best possible care

How can we help make your dental treatment experiences more comfortable or pleasant?

Please share with us anything you would like us to know about your dental treatment goals, desires, experiences or concerns.

MEDICAL HISTORY Please answer each question as accurately as possible. Feel free to add comments on the back of this form.

1. PLEASE DRAW A CIRCLE AROUND ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT.

Heart Disease or Condition	Rheumatic Fever	Asthma	Hepatitis	Sexually Transmitted Disease
Angina Pectoris	Stroke	Hay Fever	Thyroid Disease	Drug Addiction
Frequent Chest Pains	Hemophilia	Emphysema	Glaucoma	Psychiatric Treatment
High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures	Cancer
Shortness of Breath	Prolonged or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells	Radiation Therapy
Swollen Ankles	Anemia	Ulcers	AIDS or AIDS Related Complex	Chemotherapy
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive	Unexplained Weight Loss
Congenital Heart Disease	Sickle Cell Disease	Liver Disease	Cold Sores	Implant Prosthesis
Heart Murmur	Arthritis	Jaundice (Other than at birth)	Genital Herpes	or Artificial Joint

2. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?	YES	NO	HAVE YOU TAKEN BISPHOSPHONATES? (Bone density medication)	YES	NO
3. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR?				YES	NO
4. ARE YOU PRESENTLY TAKING ANY MEDICATION, DRUGS, OR PILLS? (Please list)				YES	NO
5. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS? (Please list)				YES	NO
6. HAVE YOU EVER HAD A REACTION TO LOCAL ANESTHETIC OR HAD COMPLICATIONS FOLLOWING DENTAL TREATMENT?				YES	NO
7. HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION?				YES	NO
8. DO YOU USE TOBACCO? (If YES, please circle type used and indicate how much and for how long) Cigarettes Cigars Pipe Chewing Tobacco Snuff How much? _____ For how long? _____				YES	NO
9. WOMEN: ARE YOU, MIGHT YOU BE, OR ARE YOU TRYING TO BECOME PREGNANT? If you are pregnant, please indicate which trimester you are in: ☁First ☁Second ☁Third				YES	NO
10. DO YOU WISH TO TALK PRIVATELY WITH THE DENTIST ABOUT ANY PROBLEM?				YES	NO

To the best of my knowledge, the preceding answers are correct. I will inform the dental staff of any changes. PATIENT SIGNATURE (or Parent / Legal Guardian) **X**	Date **X**	Did you add comments on the back of this form?	YES	NO

Dentist's comments

blood pressure
____

Continued on back ☐

HISTORY UPDATES I confirm that this MEDICAL HISTORY, with changes noted below, adequately states my past and present conditions.

DATE	CHANGES	PATIENT"S SIGNATURE	Dr's init	blood pressure
_____	_____	_____	_____	__________
_____	_____	_____	_____	__________
_____	_____	_____	_____	__________
_____	_____	_____	_____	__________
_____	_____	_____	_____	__________
_____	_____	_____	_____	__________
_____	_____	_____	_____	__________