Name _____ Gender _____ Age _____

Date of Appointment_____

Reason for Visit

What brings you to the office today?

Allergies

Are you allergic to any of the following?

☐ Adhesive tape ☐ Antibiotics ☐ Latex

☐ Barbiturates (Sleeping pills) ☐ Aspirin ☐ Iodine

☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any allergies? ☐ Yes ☐ No

Name	Reaction

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name	Dosage	Frequency

Hospitalization & Surgeries

Reason	Date

Dental History

When was your last dental exam?

Date: _____

When were your last dental x-rays taken?

Date: _____

How often do you brush? # times/day ____

How often do you floss? # times/day ____

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments?

☐ Yes ☐ No

Do you have any of the following?

☐ Bad Breath ☐ Dry mouth ☐ Partials

☐ Bleeding gums ☐ Difficulty Chewing ☐ Sensitivity to Cold

☐ Blisters on Mouth ☐ Ear Pain ☐ Sensitivity to Heat

☐ Broken Fillings ☐ Pacemaker ☐ Sensitivity to Sweets

☐ Clicking jaw ☐ Rheumatic Fever ☐ Sensitivity to Pressure

☐ Dentures ☐ Sinus Problem ☐ Swollen Gums

☐ Difficulty Opening or Closing ☐ Sinus Problem

Past Medical History

Have you ever had any of the following?

☐ Alchoholism ☐ Bleeding Disorder ☐ Eating Disorder

☐ Allergies ☐ Blood Disease ☐ Epilepsy

☐ Anemia ☐ Blood Transfusion ☐ Hay Fever

☐ Anxiety Disorder ☐ Bowel Disorder ☐ Heart Disease

☐ Arthritia ☐ Cancer ☐ Heart Problems

☐ Asthma ☐ Diabetes ☐ Hepatatis A, B or C

☐ AIDS/HIV ☐ Depression ☐ Highblood Pressure

☐ High Cholesterol ☐ Migranes ☐ Stomach Ulcer

☐ Joint Disorder ☐ Osteoporosis ☐ Substance Abuse

☐ Kidney Disorder ☐ Pacemaker ☐ Thyroid Disorder

☐ Liver Disorder ☐ Rheumatic Fever ☐ Tuberculosis

☐ Lung Disease ☐ Sinus Problems ☐ Veneral Disease

☐ Lupus ☐ Skin Disorder

☐ Measles ☐ Stroke

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No

Do you smoke now?

☐ Yes ☐ No

Do you use recreational drugs?

☐ Yes ☐ No

How much alchohol do you drink per week?

drinks/week: _____

How much caffeine do you drink per day?

drinks/day: _____

Women Only

Are you pregnant? ☐ Yes ☐ No

Are you breast feeding? ☐ Yes ☐ No

Are you breast feeding?

☐ Yes ☐ No

What is your method of birth control?