

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
- Barbiturates (Sleeping pills)
- Codeine
- Antibiotics
- Aspirin
- Sulfa
- Latex
- Iodine
- Local Anesthetics
- Do you have any allergies?  Yes  No

### Current Medications

Are you currently taking any blood thinners?

- Yes
- No

What medications are you currently taking?

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name	Reaction
_____	_____
_____	_____

### 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
- Bleeding gums
- Blisters on Mouth
- Broken Fillings
- Clicking jaw
- Dentures
- Difficulty Opening or Closing
- Dry mouth
- Difficulty Chewing
- Ear Pain
- Pacemaker
- Rheumatic Fever
- Sinus Problem
- Sinus Problem
- Partial
- Sensitivity to Cold
- Sensitivity to Heat
- Sensitivity to Sweets
- Sensitivity to Pressure
- Swollen Gums

### Past Medical History

Have you ever had any of the following?

- Alcoholism
- Allergies
- Anemia
- Anxiety Disorder
- Arthritis
- Asthma
- AIDS/HIV
- Bleeding Disorder
- Blood Disease
- Blood Transfusion
- Bowel Disorder
- Cancer
- Diabetes
- Depression
- Eating Disorder
- Epilepsy
- Hay Fever
- Heart Disease
- Heart Problems
- Hepatitis A, B or C
- Highblood Pressure
- High Cholesterol
- Joint Disorder
- Kidney Disorder
- Liver Disorder
- Lung Disease
- Lupus
- Measles
- Migranes
- Osteoporosis
- Pacemaker
- Rheumatic Fever
- Sinus Problems
- Skin Disorder
- Stroke
- Stomach Ulcer
- Substance Abuse
- Thyroid Disorder
- Tuberculosis
- Veneral Disease

### Lifestyle Factors

Have you ever smoked?

- Yes
- No

Do you smoke now?

- Yes
- No

Do you use recreational drugs?

- Yes
- No

How much alcohol 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?

\_\_\_\_\_