

Name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Date of last dental examination: \_\_\_\_\_

What is the reason for your visit?: \_\_\_\_\_

Do you consider yourself to be in good health?: \_\_\_\_\_ Physician: \_\_\_\_\_

Are you happy with your smile? \_\_\_\_\_

Do you smoke or use tobacco products? \_\_\_\_\_ How much and for how long? \_\_\_\_\_

Have you ever had an oral cancer exam? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Do you suffer from migraines or muscle tension headaches? \_\_\_\_\_

Are you aware of clenching or grinding your teeth? \_\_\_\_\_

Do you have a history of periodontal (gum) disease? \_\_\_\_\_

Have you ever had "deep cleanings" or root planing of your teeth? \_\_\_\_\_

Have you ever been pre-medicated with antibiotics before dental appointments? \_\_\_\_\_

Do you have a dry mouth? \_\_\_\_\_

Do you drink sodas or sports drinks? \_\_\_\_\_ How often? \_\_\_\_\_

Do you chew gum, suck on hard candy or cough drops? \_\_\_\_\_ How often? \_\_\_\_\_

Do you get fever blisters or cold sores? \_\_\_\_\_ How often? \_\_\_\_\_

Are there any other health issues we should know about? \_\_\_\_\_

History Updates: \_\_\_\_\_

**CONDITIONS:** Check conditions you have or have had in the past.

Condition	Please Explain	Condition	Please Explain
<input type="checkbox"/> Acid Reflux/GERD	_____	<input type="checkbox"/> Herpes	_____
<input type="checkbox"/> AIDS	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> HIV Positive	_____
<input type="checkbox"/> Anorexia	_____	<input type="checkbox"/> HPV (Human Papillomavirus)	_____
<input type="checkbox"/> Asthma/Inhaler	_____	<input type="checkbox"/> Joint Replacement/Date	_____
<input type="checkbox"/> Bleeding Disorders	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Blood Transfusion	_____	<input type="checkbox"/> Liver Disease	_____
<input type="checkbox"/> Bulimia	_____	<input type="checkbox"/> Migraine Headaches	_____
<input type="checkbox"/> Cancer/Treatment	_____	<input type="checkbox"/> Pacemaker/Defibrillator Implant	_____
<input type="checkbox"/> Chemical Dependency	_____	<input type="checkbox"/> Psychiatric Care	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> SBE (Subacute Bacterial Endocarditis)	_____
<input type="checkbox"/> Emphysema	_____	<input type="checkbox"/> Stroke/T.I.A.	_____
<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Thyroid Problems	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Heart Murmur	_____	<input type="checkbox"/> Ulcers	_____
<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Other _____	_____

Patient is responsible for notifying the dentist of any changes in their health or medications. **Initial** \_\_\_\_\_

**MEDICATIONS:** List medications and dosages that you are currently taking.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES:** To all medications or substances.

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