

Name \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

**Reason for Visit**

What brings you to the office today?

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

**Current Medications**

Are you currently taking any blood thinners?

Yes  No

What medications are you currently taking?

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

**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

**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
- High Blood Pressure

**Lifestyle Factors**

Have you ever smoked?

Yes  No # of years \_\_\_\_\_ # packs/day \_\_\_\_\_

Do you smoke now?

Yes  No # packs/day \_\_\_\_\_

Do you use recreational drugs?

Yes  No types? \_\_\_\_\_ # times/week \_\_\_\_\_

How much alcohol do you drink per week?

# drinks/week \_\_\_\_\_

How much caffeine do you drink per day?

# drinks/day \_\_\_\_\_

**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 other allergies?

Name	Reaction
_____	_____
_____	_____

**Hospitalizations & Surgeries**

Reason	Date
_____	_____
_____	_____
_____	_____

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
- Jaw Pain
- Loose Teeth
- Mouth Pain
- Mouth Sores
- Partialis
- Sensitivity to Cold
- Sensitivity to Heat
- Sensitivity to Sweets
- Sensitivity to Pressure
- Swollen Gums

- High Cholesterol
- Joint Disorder
- Kidney Disorder
- Liver Disorder
- Lung Disease
- Lupus
- Measles
- Migraines
- Osteoporosis
- Pacemaker
- Rheumatic Fever
- Sinus Problems
- Skin Disorder
- Stroke
- Stomach Ulcer
- Substance Abuse
- Thyroid Disorder
- Tuberculosis
- Venereal Disease

**Women Only**

Are you pregnant?

Yes  No

Are you breastfeeding?

Yes  No

What is your method of birth control?

\_\_\_\_\_