PATIENT NAME					DATE					
Primary reason for this de	ntal appointment:	Examination	Emergency		Consultation					
Dental History								Please	Circle	
Do you have a specific der	ntal problem? Describ	9						Yes	No	
Do you have dental examinations on a routine basis? Last visit								Yes	No	
Do you think you have acti	ve decay or gum disea	ase?						Yes	No	
Do you brush and floss on	a routine basis? Disc	uss							No	
Do your gums ever bleed?									No	
Do you like your smile? W									No	
Does food catch between									No	
Do you want to keep your									No No	
Do you over mare emercing, pepping or discontiners in the just joints. Do you start of grants.										
									No	
Name of previous dentist (
Date of last full mouth x-ra	vs (16 small films or p	anoramic):			W. A. C.	_				
	ус (те сппшттте стр									
Medical History					,	N		\/aa	Al-	
Are you under a physician	's care now? Why?			Who?		none		_ Yes		
Have you ever been hospi									No No	
Have you ever had a serio								-	No	
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What?									No	
Are you off a special diet? Are you allergic to any me		e? Please che							No	
Aspirin Penicillin	Codeine Acre	ic Metal	Latev Bubber	Milk	Other					
Women (Please check):									No	
Do you now have or have										
*If yes to any of the starre	ed conditions, please of	all prior to you	r appointment prem	edicati	lon or changes in medic					
Ye Heart Disease/Surgery*		Yes No	Observable	Yes	No Night Sweats	Yes No	Cold Sores		es Na	
Heart Murmur or Defect * E	☐ Sickle Cell Disease		Osteonomsis	Н	☐ Yellow Jaundice	5 5	Fever Blisters		J C	
Irregular Heart Beat	☐ Hemophilia		Chemotherapy Osteoporosis Bisphosphonates		☐ Kidney Problems		Herpes			
Angina/Chest Pain E Heart Attack/Failure E	I □ Methemoglobinem I □ Leukemia		Osteonecrosis of Jaw Aredia I.V. Reclast I.V.		☐ Renal Dialysis ☐ Thyroid Disease		Stroke Convulsions	Ī		
Congenital Heart Disorder*	Recent Blood Tran	sfusion 🗆 🗆	Zometa I V	П	☐ Parathyroid Disease	5 5	Epilepsy or Seizures] [
Mitral Valve Prolapse * C			Fosamax, Actonel, Bon	va 🛚	☐ Arthritis/Gout ☐ Rheumatism		Fainting or Dizziness] [] [
Rheumatic Fever *	☐ Breathing Problem		Stomach/Intestinal Dise Ulcers	ase ∐	☐ Pain in Jaw Joints		Glaucoma Tumors or Growths		jē	
Artificial Heart Valve * E	=	th	Recent Weight Loss		☐ Cortisone Medicine		Nervousness		ם ב	
Heart Pace Maker* L Pulmonary Shunt*	Frequent Cough Hay Fever		Recent Weight Loss Frequent Diarrhea		Artificial Joint *		Psychiatric Care			
High Blood Pressure	Sinus Trouble	₫₫	Diabetes Excessive Thirst		Sexually Transmitted Disc		Alzheimer's Disease Allergies (Medicines)		ם כ	
Low Blood Pressure Bacterial Endocarditis*	Asthma Bloody Sputum				☐ HIV Positive	<u> </u>	Allergies (Pollen / Du	ust) [3 0	
Unexplained Fever	☐ Emphysema	55	Hypoglycemia Liver Disease	П	☐ Genital Hernes		Hives or Rash	, [
Bruise Easily/Blood Disease L	☐ Tuberculosis		Hepatitis A (Infectious)	吕	☐ Drug Addiction/Alcoho ☐ Tattoos/Body Piercing		Ever taken fen-phen	? L 2* [ם כ	
Anemia	Cancer X-Ray Treatments	Badiation)	Protease Inhibitor		☐ Sleep Apnea	<u> </u>	Cochlear implants?		5 6	
Have you ever had any o							The second of th	Yes	No	
•								Yes		
Do you wish to talk to the To the best of my knowledge, all the	ne preceding answers are cor	rect. If I have any c	hanges in my health status (r if my n	nedicines change, I shall inform	the dentist as	nd staff at the next appoint			
					_					
PATIENT SIGNATURE (PAR					Date					
•	•				Data	op.	Pulso			
Reviewed By Doctor					_Date	>P	Fulse			
History Review and Sign	ificant Findings	1.2		, N		S 1 24 2 2				
		1 44 1 44 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		<u> </u>			<u> </u>			
Medical Updates										
	LUOTODY data d		·		un that it adam chalv atai	t	nd areasat sandition			
I have read my MEDICAI	. HISTORY dated	Tan available	and							
DATE EXCEPTIONS			The State of Light S		PATIENT'S SIGNATURE			BY	- 1	
			NUIG				Dr			
			None				Dr			
					a ga ga sa Sa. A					
			None				Dr			