

DENTAL HISTORY UPDATE

Patient: _____	Date: _____	Age _____
DOB: _____	Wt: _____	Ht: _____
Occupation: _____		

	Yes	No
Are you presently in good health?	<input type="checkbox"/>	<input type="checkbox"/>
Past serious illnesses? <i>If yes, please explain:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you being treated for any illnesses? <i>List:</i> _____ <i>List medications you are currently taking:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to medications or other substances? <i>List:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Date of last dental exam? _____		
Date of last physical exam? _____		
Are you pregnant? <i>Delivery Date:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had surgery? <i>List:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Reactions to anesthesia? <i>List:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco products? <i>History:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcohol? <i>Describe usage:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Other dentists seen for your problem? <i>List:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you have a past history of:					
	Yes	No		Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Street Drug Use	<input type="checkbox"/>	<input type="checkbox"/>
			Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>
			Bad Scarring	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Family History of:					
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Anesthetic Problems	<input type="checkbox"/> Asthma	
<i>Describe:</i> _____					