

Patient's Name _____ Date of Birth _____ Soc. Sec. No. _____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

MEDICAL HISTORY

Medical Doctor's Name _____ City _____ Phone _____

Are you in good health? _____ Yes _____ No

Are you now under the care of a physician? _____ Yes _____ No

If so, what is the condition being treated? _____

Have you had any serious illness or operation? _____ Yes _____ No

If so, what was that illness or operation? _____

Do you smoke — what and how much _____ Yes _____ No

Have you ever had any excessive bleeding requiring special treatment? _____ Yes _____ No

Are you now receiving any medication? _____ Yes _____ No

If so, please list _____

Are you allergic or have you reacted adversely to: Local anesthetics, Penicillin or other antibiotics, Sulfa drugs, Barbituates, sedatives, sleeping pills, Aspirin, Codeine or any other medication not listed? _____

My last physical examination was on _____

Please indicate year of occurrence for any of the following conditions you have had or have at present: _____

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Trans. Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis, Gonorrhea, Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesion	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Latex	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>

Do you urinate frequently _____ Yes _____ No

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are very tired? _____ Yes _____ No

Do your ankles swell during the day? _____ Yes _____ No

Do you use more than 2 pillows to sleep? _____ Yes _____ No

Have you lost or gained more than 10 pounds in the past year? _____ Yes _____ No

Do you ever wake up from sleep short of breath? _____ Yes _____ No

Are you on a special diet? _____ Yes _____ No

Are you thirsty much of the time _____ Yes _____ No

Do you have any disease, condition or problem not listed above? _____ Yes _____ No

If so, explain _____

WOMEN

Are you pregnant _____ Yes _____ No

Do you take oral contraceptives? _____ Yes _____ No

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change on my health, or if my medications change, I will inform the doctor of dentistry at the next appointment without fail. Permission is given to do the dental work agreed upon and to use local anesthetics, analgesics, sedatives and x-rays as deemed necessary by the doctor.

Date					
Initial	PATIENT	PATIENT	PATIENT	PATIENT	PATIENT
	DDS	DDS	DDS	DDS	DDS

Patient's or Guardian's Signature Date

Doctor's Signature

CHARTING

DATE _____

M																
PD2																
PD1																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

RIGHT A B C D E F G H I J LEFT

PD1																
PD2																
M																

RED ALERT **PULSE** **B P**

/

SOFT TISSUES

soft palate	
hard palate	
floor of mouth	
tongue	
verruca	
buccal mucosa	
TMJ	
skin	
lips	
pharynx	
tonsils	
lymph nodes	
explanatory	
comments	

OCCUSION

Class I
Class II
 Div 1
 Div 2
Class III
Dev Swallowing Habit
 Yes No

CHEWING HABITS

bruxism
clenching
cheek biting
percussion

DIAGNOSIS OF PERIODONTIUM

HEALTHY GINGIVITIS MILD MODERATE SEVERE
 PERIODONTITIS MILD MODERATE ADVANCED

TREATMENT PLANS

DATE	TOOTH			
	1			
	2			
	3			
	A 4			
	B 5			
	C 6			
	D 7			
	E 8			
	F 9			
	G 10			
	H 11			
	I 12			
	J 13			
	14			
	15			
	16			
	17			
	18			
	19			
	K 20			
	L 21			
	M 22			
	N 23			
	O 24			
	P 25			
	Q 26			
	R 27			
	S 28			
	T 29			
	30			
	31			
	32			

PERIODONTIUM

Area

recession	
healthy pink	
hemorrhagic red	
edematous	
loss of stipple	
loss of anatomy	
exudate	
bleeding general	
bleeding w/probe	

plaque	n	s	m	h
stain	n	s	m	h

supraging calc.	n	s	m	h
subging calcs.	n	s	m	h

PROSTHESIS EVALUATION

type/area	insertion date	condition or replace?
upper		
lower		

CROWN & BRIDGE INSERTION DATES

TOOTH	DATE

SUGGESTED REFERRALS

Oral Surgeon
 Periodontist
 Endodontist
 Orthodontist
 Med. Doctor
 Other _____

Removable Prosthetics

Upper
 type _____
 # replaced _____
 # clasped _____
 relined repair _____
 Lower
 type _____
 # replaced _____
 # clasped _____
 relined repair _____
 explanatory _____
 comments _____