## GLENN R. BURNS, D.D.S., F.A.G.D AND JENNIFER J. LAPE, D.D.S.

Patient's name: ________________________________ Date of birth: __________________

### DENTAL HISTORY

Why have you come to the dentist today? ____________________________________________
Approximate date of last dental exam ________________________________________________
Are you currently in pain? **Y N** If yes, please describe _____________________________
Have you experienced problems associated with any previous dental care? **Y N**
Do you or have you experienced pain/discomfort in your jaw joint (TMJ, TMD)? **Y N**
Do you floss daily? **Y N** Do you brush daily? **Y N** Would you like whiter teeth? **Y N**
Would you like fresher breath? **Y N** Are your teeth sensitive? **Y N** If yes, to hot or cold? ____
Do you use tobacco products? **Y N** If yes, what type? __________ How much a day? _______
Are you happy with the way your smile looks? **Y N** If not, what would you change?
______________________________________________________________________________

### MEDICAL HISTORY

Name of physician: ____________________________ Date of last exam: ________________
Are you currently under the care of a physician? **Y N** If yes, please explain: ______________
______________________________________________________________________________
Please list all current medications that you are taking including over the counter medications, including herbal supplements. ________________________________________________
______________________________________________________________________________
Please list all allergies to medication. ____________________________________________
______________________________________________________________________________

***PLEASE SELECT YES OR NO***

**Conditions**

**Y N Acid Reflux**
**Y N Alcohol Usage** __daily __social
**Y N Allergies**
- **Y N** Latex Allergy
- **Y N** Metals, Jewelry
- **Y N** Seasonal Allergies

**Y N Artificial Joints**
- **Y N** Hip, Knee other ________

**Y N Arthritis** type ____________
**Y N Blood Disorders**
- **Y N** Anemia
- **Y N** Bruise Easily
- **Y N** Excessive Bleeding
- **Y N** Hemophilia
- **Y N** High Blood Pressure
- **Y N** Low Blood Pressure
- **Y N** Sickle Cell

**Y N Cancer** type ______________
- **Y N** Chemotherapy
- **Y N** Radiation

**Y N Diabetes**
**Y N Drug Addiction**

**Y N Epilepsy**
- **Y N** Fainting Spells
- **Y N** Seizures

**Y N Gall Bladder Disease**
**Y N Glaucoma**
**Y N Heart Problems**
- **Y N** Angina
- **Y N** Attack
- **Y N** Mitral Valve Prolapse
- **Y N** Murmur
- **Y N** Rheumatic Fever
- **Y N** Pacemaker
- **Y N** Stints
- **Y N** Stroke
- **Y N** Surgery
- **Y N** Other ___________

**Y N Hepatitis** type _________
**Y N Herpes/Cold Sores**
**Y N HIV/AIDS/ARC**
**Y N Home Oxygen Use**
setting ________________
**Y N Implants** type _________
**Y N Kidney Disorder**

**Y N Liver Disease**
- **Y N** Jaundice

**Y N Lung Disease**
- **Y N** Asthma
- **Y N** Emphysema
- **Y N** Tuberculosis

**Y N MRSA**
**Y N Multiple Sclerosis**
**Y N Pain Management**
**Y N Psychiatric Treatment**
**Y N Shingles**
**Y N Thyroid Disease**
**Y N Ulcers**
**Y N Venereal Disease**

**Please list all past/recent surgeries** _______________
________________________
________________________
________________________

**Please list any other conditions not listed above**
________________________
________________________

**OVER**

## FOR WOMEN ONLY

Are you pregnant? **Y N**
Are you nursing? **Y N**
Are you taking birth control? **Y N**
Do you understand that antibiotics may reduce the effectiveness of birth control pills? **Y N**

## DISCLOSURE

*To the best of my knowledge, all of the information on both sides of this form is correct and true. If there are any changes in my health, or my medications, I will inform the doctor prior to any treatment.*
*I understand that any and all personal information that I provide to this office is strictly confidential.*
*I understand that my health history information that I have provided above is necessary for diagnosis of treatment.*

_______________________________________________________________________________

**Signature of Patient/Guardian** **Date**

**Office Use Only:** Medical History Update: **Is a premedication required for this patient?** ________
I have reviewed the patient's medical history and the above (including any changes) is accurate:

Date __________ Initials ________ Comments ______________________________________________

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**OVER**