

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 Epilepsy	Y N Liver Disease
Y N Alcohol Usage __daily __social	Y N Fainting Spells	Y N Jaundice
Y N Allergies	Y N Seizures	Y N Lung Disease
Y N Latex Allergy	Y N Gall Bladder Disease	Y N Asthma
Y N Metals, Jewelry	Y N Glaucoma	Y N Emphysema
Y N Seasonal Allergies	Y N Heart Problems	Y N Tuberculosis
Y N Artificial Joints	Y N Angina	Y N MRSA
Y N Hip, Knee other _____	Y N Attack	Y N Multiple Sclerosis
Y N Arthritis type _____	Y N Mitral Valve Prolapse	Y N Pain Management
Y N Blood Disorders	Y N Murmur	Y N Psychiatric Treatment
Y N Anemia	Y N Rheumatic Fever	Y N Shingles
Y N Bruise Easily	Y N Pacemaker	Y N Thyroid Disease
Y N Excessive Bleeding	Y N Stents	Y N Ulcers
Y N Hemophilia	Y N Stroke	Y N Venereal Disease
Y N High Blood Pressure	Y N Surgery	Please list all past/recent
Y N Low Blood Pressure	Y N Other _____	surgeries _____
Y N Sickle Cell	Y N Hepatitis type _____	_____
Y N Cancer type _____	Y N Herpes/Cold Sores	_____
Y N Chemotherapy	Y N HIV/AIDS/ARC	_____
Y N Radiation	Y N Home Oxygen Use	Please list any other
Y N Diabetes	setting _____	conditions not listed above
Y N Drug Addiction	Y N Implants type _____	_____
	Y N Kidney Disorder	_____

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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