Dental and Medical History

Office Address
Carlisle Pike Family Dentisitry
5007 Carlisle Pike
Mechanicsburg, PA 17050
USA

Contact No.
717-288-5998

Patient Name: ____ Date:__________________

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History *(please check yes or no)*

Do you have a specific dental problem? ☐ Yes ☐ No
Describe: ____

Do you have dental examinations on a routine basis? ☐ Yes ☐ No
Date of Last Visit: ____

Do you think you have active decay or gum disease? ☐ Yes ☐ No
Discuss: ____

Do you brush and floss on a routine basis? ☐ Yes ☐ No
Discuss: ____

Do your gums ever bleed? ☐ Yes ☐ No
Discuss: ____

Do you like your smile? ☐ Yes ☐ No
Why? ____

Does food catch between your teeth? ☐ Yes ☐ No

Do you have any loose teeth? ____

Do you want to keep your remaining teeth? ☐ Yes ☐ No
Discuss: ____

Do you ever have clicking, popping or discomfort in the jaw joint? ☐ Yes ☐ No
Discuss: ____

Do you brux or grind? ☐ Yes ☐ No
Discuss: ____

Have your past experiences in a dental office always been positive? ☐ Yes ☐ No
Discuss: ____

Do you smoke or chew? Do you have any sores in your mouth? ☐ Yes ☐ No
Discuss: ____

Name of previous dentist (optional) ____

Date of last full mouth x-rays (16 small films or panoramic): _______________________

Date of last bitewing x-rays (looks for cavities between teeth): ____________________

Office Address
Carlisle Pike Family Denitsitry
5007 Carlisle Pike
Mechanicsburg, PA 17050
USA

Contact No.
717-288-5998

Dental and Medical History

Medical History *(please check yes or no)*

Patient Name: ______________________________ Date: ____________

Home Phone: ______________________ Business/Cell Phone: ____________________

Birthdate: ______________________ Gender: ☐ M ☐ F

Are you under a physician's care now? ☐ Yes ☐ No
Why? ____________ Who? ____________ Phone? ____________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
Discuss ______________________________

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No
What? ______________________________

Are you on a special diet? ☐ Yes ☐ No
Discuss ______________________________

Do you use tobacco products? ☐ Yes ☐ No
How Often? ______________________________

Do you drink alcohol ☐ Yes ☐ No
How Often? ______________________________

Are you allergic to any medications or substances? ____________________ ☐ Yes ☐ No
Please check box below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber

☐ Other ______________________________

Women *(please check all that apply)*
☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Do you now have or have you ever had any of the following? *(please check appropriate boxes)*

	Yes/No		Yes/No		Yes/No
Heart Trouble/Disease	☐ ☐	Bloody Sputum	☐ ☐	Stroke	☐ ☐
Heart Murmur	☐ ☐	Fainting or Dizziness	☐ ☐	Glaucoma	☐ ☐
Angina/Chest Pain	☐ ☐	Psychiatric Care	☐ ☐	Emphysema	☐ ☐
Heart Attack	☐ ☐	Nervousness	☐ ☐	Tuberculosis	☐ ☐
Congenital Heart Disorder	☐ ☐	Bruise or Bleed Easily	☐ ☐	X-Ray Treatment *(Radiation)*	☐ ☐
Mitral Valve Prolapse	☐ ☐	Anemia	☐ ☐	Chemotherapy	☐ ☐
Rheumatic Fever	☐ ☐	Sickle Cell Disease	☐ ☐	Stomach/Intestinal Disease	☐ ☐
Artificial Heart Valve	☐ ☐	Hemophilia *(Bleeding Problems)*	☐ ☐	Recent Weight Loss/Gain	☐ ☐
Heart Pace Maker	☐ ☐	Leukemia	☐ ☐	Stomach Ulcers	☐ ☐
Coronary Stent	☐ ☐	Mouth Ulcers	☐ ☐	Frequent Diarrhea	☐ ☐
High Blood Pressure	☐ ☐	Recent Blood Transfusion	☐ ☐	Diabetes	☐ ☐
Low Blood Pressure	☐ ☐	Lung Disease	☐ ☐	Excessive Thirst	☐ ☐
Blood Disease	☐ ☐	Swelling of Limbs	☐ ☐	Hypoglycemia	☐ ☐
Alcoholism	☐ ☐	Breathing Problem	☐ ☐	Sinus Trouble	☐ ☐
Liver Disease	☐ ☐	Shortness of Breath	☐ ☐	Drug Addiction	☐ ☐
Yellow Jaundice	☐ ☐	Frequent Cough	☐ ☐	Tumors or Growths	☐ ☐
Cold Sores	☐ ☐	Asthma	☐ ☐	Allergies *(Pollen/Dust)*	☐ ☐
HIV+/AIDs	☐ ☐	Immuno Compromised	☐ ☐	Fever Blisters/Herpes	☐ ☐
*CD4 count*________		Venereal Disease	☐ ☐	Genital Herpes	☐ ☐
Hives or Rash	☐ ☐	Kidney Problems	☐ ☐	Thyroid Problems	☐ ☐
Parathyroid Disease	☐ ☐	Arthritis/Gout	☐ ☐	Pain in Jaw Joints	☐ ☐
Cortisone/Steroids	☐ ☐	Artificial Joint	☐ ☐	Epilepsy	☐ ☐
Hepatitis A *(Infectious)*	☐ ☐	Hepatitis B or C	☐ ☐	Convulsions/Seizures	☐ ☐
		Need Medication B/F Dental Appt.	☐ ☐		

CARLISLE PIKE
FAMILY
DENTISTRY

Dental and Medical History

Office Address
Carlisle Pike Family Dentisitry
5007 Carlisle Pike
Mechanicsburg, PA 17050
USA

Contact No.
717-288-5998

Medical History *(please check yes or no)*

Patient Name: ____ Date:____________

Have you ever had any other serious illness not checked above? ☐ Yes ☐ No
Discuss ____

Do you wish to talk to the dentist privately about any problems? ☐ Yes ☐ No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change I shall inform the dentist and staff at the next appointment without fail.

Patient Signature: ____ Date:_______________
(Parent or Guardian)

Reviewed by Doctor ____________ Date _______________ BP ______________
History Review and Significant Findings _______________________________________

Medical Updates

I have read my Medical History, dated ________________ and confirm that it adequately states past and present conditions.

Date	Exceptions	None	Patient's Signature	BP	Reviewed By