

Full Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Home Address \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Business Address \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Dental Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_  
 Referred By \_\_\_\_\_ Previous Dentist \_\_\_\_\_  
 Name of Physician \_\_\_\_\_ Phone No. \_\_\_\_\_  
 In Case of Emergency Contact \_\_\_\_\_ Phone No. \_\_\_\_\_

**Medical History**

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

			Yes	No
1. Have you ever been hospitalized, major operations or serious illness? .....			<input type="checkbox"/>	<input type="checkbox"/>
If so, what? _____				
2. Are you under any medical treatment now? .....			<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had any allergic reactions to any drugs including penicillin, codeine, novocaine, aspirin? .....			<input type="checkbox"/>	<input type="checkbox"/>
4. Has there been a change in your health in the past year? .....			<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had a blood transfusion? .....			<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had kidney dialysis treatment? .....			<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had abnormal bleeding problems after a cut or tooth extraction? .....			<input type="checkbox"/>	<input type="checkbox"/>
8. Are you now taking drugs or medications? .....			<input type="checkbox"/>	<input type="checkbox"/>
If so, what? _____				
9. Has a physician ever informed you that you had:				
	Yes	No		
Heart Ailment .....	<input type="checkbox"/>	<input type="checkbox"/>		
High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>		
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>		
Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>		
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Disease .....	<input type="checkbox"/>	<input type="checkbox"/>		
Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>		
			Yes	No
Hepatitis or Yellow Jaundice .....			<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease .....			<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease .....			<input type="checkbox"/>	<input type="checkbox"/>
AIDS .....			<input type="checkbox"/>	<input type="checkbox"/>
Stomach or Intestinal Disease .....			<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease .....			<input type="checkbox"/>	<input type="checkbox"/>
Tumors or Growths .....			<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....			<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis .....			<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease .....			<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy .....			<input type="checkbox"/>	<input type="checkbox"/>
10. Women: A. Are you pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>		
B. Estimated Date of Delivery _____				

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Updating \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medical History Summary**

**Blood Pressure:**



**Clinical Examination**

Date \_\_\_\_\_

**Extraoral**

Head \_\_\_\_\_  
Skin \_\_\_\_\_  
Eyes \_\_\_\_\_  
Neck \_\_\_\_\_  
Lips \_\_\_\_\_  
Lymph Nodes \_\_\_\_\_

**Gingiva**

Architecture \_\_\_\_\_  
Color \_\_\_\_\_  
Tone \_\_\_\_\_  
Suppuration \_\_\_\_\_  
Hemorrhage \_\_\_\_\_  
Recession \_\_\_\_\_  
Calculus/plaque \_\_\_\_\_  
Hypersensitivity \_\_\_\_\_  
Mucogingival \_\_\_\_\_

**Myofascial Pain Dysfunction**

Clicking \_\_\_\_\_  
Crepitus \_\_\_\_\_  
Trismus \_\_\_\_\_  
Muscle spasms (pain) \_\_\_\_\_  
Headaches \_\_\_\_\_  
Tinnitus \_\_\_\_\_  
Subluxation \_\_\_\_\_

Updating \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Intraoral**

Mucosa \_\_\_\_\_  
Frenuli \_\_\_\_\_  
Palate \_\_\_\_\_  
Floor of mouth \_\_\_\_\_  
Tongue \_\_\_\_\_  
Salivary glands \_\_\_\_\_  
Tori \_\_\_\_\_

**Occlusion**

Angle Class R \_\_\_\_\_ L \_\_\_\_\_  
Overbite \_\_\_\_\_  
Overjet \_\_\_\_\_  
Crossbite areas \_\_\_\_\_  
Wear facets \_\_\_\_\_  
Diastemas \_\_\_\_\_  
Fremitus \_\_\_\_\_  
Cuspid protected \_\_\_\_\_  
Group function \_\_\_\_\_  
Anterior guidance \_\_\_\_\_  
Premature contacts \_\_\_\_\_  
Open contacts \_\_\_\_\_

**X-Rays**

Alveolar Crest (type of bone loss) \_\_\_\_\_  
Lamina dura \_\_\_\_\_  
Perio space \_\_\_\_\_  
Furcation \_\_\_\_\_  
Retained roots \_\_\_\_\_  
Maxillary sinus \_\_\_\_\_  
Impactions \_\_\_\_\_  
Calculus \_\_\_\_\_  
Caries \_\_\_\_\_  
Faulty restorations \_\_\_\_\_  
Periapical & pulp pathology \_\_\_\_\_  
Crown/root ratio (unfavorable) \_\_\_\_\_

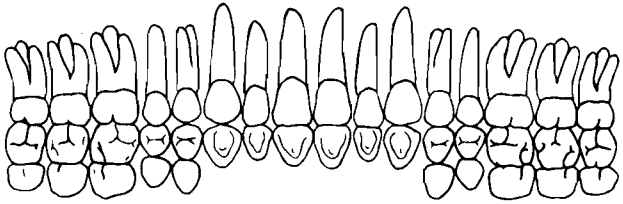
Clinical Examination Summary



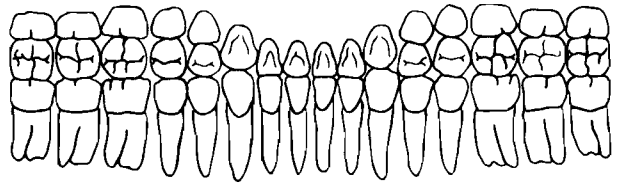
## Subsequent Dental Examinations

Date \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket Depth	B															
	L															
Mobility																



RIGHT
LEFT



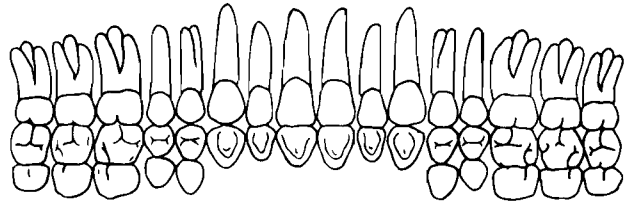
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Pocket Depth	B															
	L															
Mobility																

Remarks:

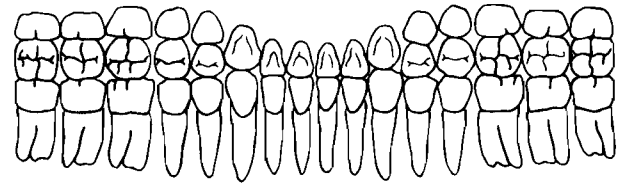
Hygiene:

Date \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket Depth	B															
	L															
Mobility																



RIGHT
LEFT



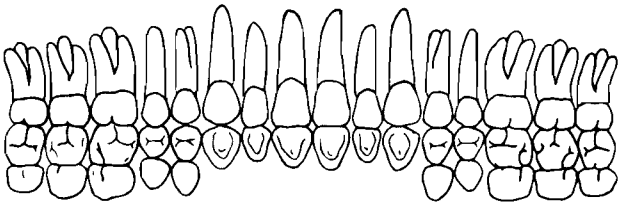
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Pocket Depth	B															
	L															
Mobility																

Remarks:

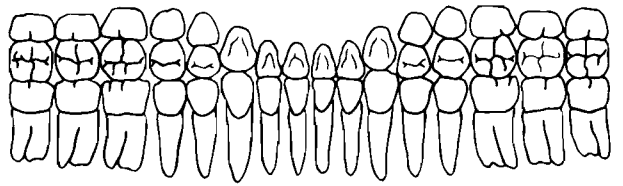
Hygiene:

Date \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket Depth	B															
	L															
Mobility																



RIGHT
LEFT



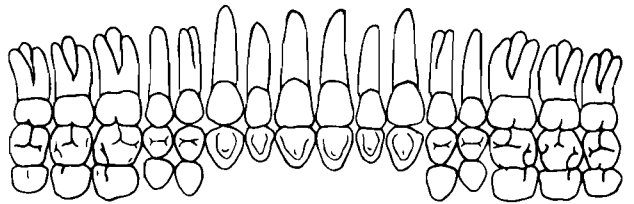
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Pocket Depth	B															
	L															
Mobility																

Remarks:

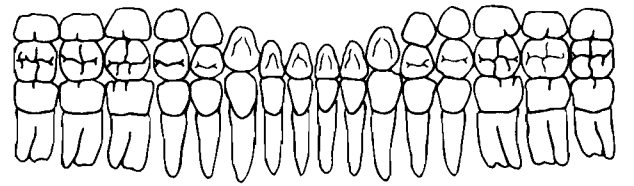
Hygiene:

Date \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket Depth	B															
	L															
Mobility																



RIGHT
LEFT



	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Pocket Depth	B															
	L															
Mobility																

Remarks:

Hygiene:

