OAK CLIFF DENTAL CARE

4640 NICOLS ROAD • SUITE 100 • EAGAN, MINNESOTA 55122 • (651) 454-1414

PATIENT NAME _____ **TODAY'S DATE** _____

Patient Birthdate _____

Date Of Last Checkup _____

Dental History

	Please Circle		*Describe Or Comment*
Do you have a specific dental problem?	Yes	No	_____
Are your teeth sensitive to hot, cold or biting?	Yes	No	_____
Do you think you have active decay or gum disease?	Yes	No	_____
Do your gums ever bleed?	Yes	No	_____
Have you ever been treated for periodontal disease?	Yes	No	_____
Would you like to improve your smile or whiten your teeth?	Yes	No	_____
Does food catch between your teeth? Any loose teeth?	Yes	No	_____
Do you want to keep your remaining teeth?	Yes	No	_____
Do you have noise or discomfort in the jaw joint? Do you grind?	Yes	No	_____
Have your past experiences in a dental office always been positive?	Yes	No	_____
Do you smoke or chew? Any sores or growths in your mouth?	Yes	No	_____

I brush _____ times a day and floss _____ times a week.

Name of previous dentist: _____

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

Medical History

	Please Circle		*Describe Or Comment*
Are you under a physician's care now?	Yes	No	_____ Drs. Name & Phone #: _____
Have you ever been hospitalized or had a major operation?	Yes	No	_____
Have you ever had a serious injury to your head or neck?	Yes	No	_____
Are you taking any medications, pills or drugs?	Yes	No	_____
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): ☐ 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.
*** If yes to any of the starred conditions, please call prior to your appointment… premedication may be required.**

	Yes		Yes		Yes		Yes		Yes
Heart Trouble/Disease	☐	Bruise Easily	☐	Emphysema	☐	Yellow Jaundice	☐	Cold Sores	☐
Heart Murmur *	☐	Anemia	☐	Tuberculosis	☐	Kidney Problems	☐	Fever Blisters	☐
Irregular Heart Beat	☐	Excessive Bleeding	☐	Cancer	☐	Renal Dialysis	☐	Herpes	☐
Angina/Chest Pain	☐	Sickle Cell Disease	☐	X-Ray Treatments (Radiation)	☐	Thyroid Disease	☐	Stroke	☐
Heart Attack/Failure	☐	Hemophilia (Bleeding Problem)	☐	Chemotherapy	☐	Parathyroid Disease	☐	Convulsions	☐
Congenital Heart Disorder	☐	Leukemia	☐	Stomach/Intestinal Disease	☐	Arthritis/Gout	☐	Epilepsy or Seizures	☐
Mitral Valve Prolapse *	☐	Recent Blood Transfusion	☐	Ulcers	☐	Rheumatism	☐	Fainting or Dizziness	☐
Scarlet Fever	☐	Swelling of Limbs	☐	Recent Weight Loss	☐	Pain in Jaw Joints	☐	Glaucoma	☐
Rheumatic Fever *	☐	Lung Disease	☐	Frequent Diarrhea	☐	Cortisone Medicine	☐	Tumors or Growths	☐
Artificial Heart Valve *	☐	Breathing Problem	☐	Diabetes	☐	Artificial Joint *	☐	Nervousness	☐
Heart Pace Maker *	☐	Shortness of Breath	☐	Excessive Thirst	☐	Venereal Disease	☐	Psychiatric Care	☐
Heart Surgery *	☐	Frequent Cough	☐	Hypoglycemia	☐	AIDS	☐	Alzheimer's Disease	☐
High Blood Pressure	☐	Hay Fever	☐	Liver Disease	☐	HIV Positive	☐	Allergies (Medicines)	☐
Low Blood Pressure	☐	Sinus Trouble	☐	Hepatitis A (Infectious)	☐	Genital Herpes	☐	Allergies (Pollen/Dust)	☐
Blood Disease	☐	Asthma	☐	Hepatitis B or C	☐	Drug Addiction	☐	Hives or Rash	☐

Have you ever had any other serious illness not checked above? Yes No _____

Do you wish to talk to the dentist privately about any problem? Yes No _____

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

X _____ Date _____

PATIENT SIGNATURE (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		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____