FURNISS FAMILY DENTISTRY

PATIENT NAME: _____ **DATE:** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe: _____	Yes No
Do you have dental examinations regularly? Last visit? _____	Yes No
Do you think you have active decay or gum disease? _____	Yes No
Do you brush and floss on a routine basis? Discuss: _____	Yes No
Do you like your smile? Why or why not? _____	Yes No
Do your gums ever bleed? Discuss: _____	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 ever have clicking, popping or discomfort in the jaw joint? Do you grind your teeth? _____	Yes No
Do you smoke or chew? Discuss any sores or growths in your mouth: _____	Yes No
Have you ever had any bad dental experiences? _____	Yes No
Previous dentist name (optional), and date of last complete exam/x-rays: _____	Yes No

MEDICAL HISTORY

Please list your Primary Care Physician: _____	Yes No
Have you ever been hospitalized or had a major operation? Discuss: _____	Yes No
Have you ever had a serious injury to your head or neck? Discuss: _____	Yes No
Are you on a special diet? Any known health issues? _____	Yes No

WOMEN (Please check if applicable): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives _____

MEDICATIONS: Are you taking any medications, pills, or drugs? Please list: _____

ALLERGIES: If you have any known drug allergies, please check box below:

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

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Cold Sores	☐	☐
Heart Murmur	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Stroke	☐	☐
Irregular Heartbeat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Epilepsy or Seizure	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Radiation Therapy	☐	☐	Thyroid Disease	☐	☐	Fainting/Dizziness	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia	☐	☐	Chemotherapy	☐	☐	Arthritis/Gout	☐	☐	Glaucoma	☐	☐
Heart Valve Problem	☐	☐	Leukemia	☐	☐	GI Tract Disease	☐	☐	Pain in Jaw Joints	☐	☐	Tumors/Growths	☐	☐
Blood Disease	☐	☐	Swelling of limbs	☐	☐	Recent Weight Loss	☐	☐	Artificial Joint	☐	☐	Anxiety	☐	☐
Heart Pacemaker	☐	☐	Lung Disease	☐	☐	Diabetes	☐	☐	Venereal Disease	☐	☐	Psychiatric Care	☐	☐
Heart Surgery	☐	☐	Breathing Problem	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Alzheimer's	☐	☐
High Blood Pressure	☐	☐	Frequent Cough	☐	☐	Hepatitis A	☐	☐	AIDS	☐	☐	Allergies	☐	☐
Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis B	☐	☐	Drug Addiction	☐	☐	Hives or Rash	☐	☐

If you have had any other serious illness not checked above, please describe: _____

MEDICAL UPDATES

You will be asked at future appointments if there has been any change to your health history or medications. Please tell Dr. Furniss or his staff of any changes as they must be recorded in your digital dental chart.

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

_____

PATIENT SIGNATURE (Parent or Guardian) DATE

1000 Titus St. Gilmer, TX 75644 903.843.5607 www.furnissfamilydentistry.com