Why did you leave your last dentist? _____

What did you like least about your last dentist:? _____

What did you like most about any dental office you have gone to? _____

What are you expecting to have done today? _____

Are you having any dental pain or discomfort at this time? _____

Are you happy with your smile? _____

If you could change one thing about your smile what would it be? _____

Initial to authorize Dr. Licking to use your x-rays or photographs for teaching purposes. _____

PATIENT HEALTH HISTORY

HOW WOULD YOU DESCRIBE YOUR HEALTH? _____ DATE OF LAST MEDICAL EXAM _____

NAME OF PHYSICIAN _____

YES	NO	
☐	☐	Are you now or have you been under the care of a physician with the past two years? _____
☐	☐	Are you pregnant? Month: _____
☐	☐	Are you now or have you recently been taking any medication? _____
☐	☐	Have you experienced any ill effects or allergy to any medication? (penicillin, novacaine, codeine, aspirin) _____
☐	☐	Have you ever had a skin reaction to any metal? _____
☐	☐	Do you grind or clench your teeth? _____
☐	☐	Have you had any major surgery or hospitalization? _____ Date _____

HAVE YOU HAD:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Failure	☐	☐	Heart Pacemaker	☐	☐	Sinus Trouble	☐	☐	Drug Addiction
☐	☐	Heart Disease or Attack	☐	☐	Heart Surgery	☐	☐	Diabetes	☐	☐	Cold Sores
☐	☐	Angina Pectoris	☐	☐	Artificial Joint	☐	☐	Cancer	☐	☐	Fainting/Dizzy Spells
☐	☐	High Blood Pressure	☐	☐	Mitral Valve Prolapse	☐	☐	Glaucoma	☐	☐	Bleeding Gums
☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐	Pain in Jaw Joints	☐	☐	Bad Breath
☐	☐	Rheumatic Fever	☐	☐	Kidney Trouble	☐	☐	Epilepsy or Seizures	☐	☐	Chronic Headaches
☐	☐	Congenital Heart Defect	☐	☐	Ulcers	☐	☐	AIDS	☐	☐	Chronic Neckaches
☐	☐	Scarlet Fever	☐	☐	Tuberculosis (TB)	☐	☐	Hepatitis	☐	☐	Blood Disorder
☐	☐	Artificial Heart Valve	☐	☐	Asthma	☐	☐	Liver Disease			

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform this office at the next appointment without fail.

Date _____ Signature of Patient, Parent or Guardian _____

Relationship to patient _____

MEDICAL HISTORY UPDATE/CHANGES

Date	Changes	Initial
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____