

**TODD A. GATHRIGHT, DDS, PA**

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**DENTAL/MEDICAL HISTORY**

**PRINT PATIENT'S NAME:** \_\_\_\_\_

**BIRTHDATE:** \_\_\_\_\_

**DENTAL HISTORY**

PURPOSE of INITIAL VISIT:	
HOW LONG SINCE you have seen a dentist?	
Date of Last COMPLETE Dental Exam:	
Date of Last FULL MOUTH X-RAYS (16 small films or panoramic):	
Do you REGULARLY BRUSH and use DENTAL FLOSS?	YES NO
Do your GUMS ever BLEED?	YES NO
Have you had any PERIODONTAL (GUM) TREATMENTS?	YES NO
Does food get CAUGHT between your teeth?	YES NO
Are you teeth ever SENSITIVE? Circle: HOT COLD SWEETS PRESSURE	
Do you ever have CLICKING, POPPING, OR DISCOMFORT IN THE JAW JOINT?	YES NO
Do you CLENCH OR GRIND your teeth?	YES NO
Have you LOST any teeth or have any teeth been REMOVED?	YES NO
How were these teeth REPLACED? Circle: FIXED BRIDGE REMOVABLE BRIDGE DENTURE NOT REPLACED	
Are you UNHAPPY with the replacement?	YES NO
Would you like to know about PERMANENT REPLACEMENT?	YES NO
Do you have any SORES or GROWTHS in your mouth?	YES NO
Do you feel your BREATH is offensive at times?	YES NO
Are you APPREHENSIVE about dental treatment?	YES NO
Have you ever had ORTHODONTIC work?	YES NO
Are any of your teeth LOOSE, TIPPED, SHIFTED, OR CHIPPED?	YES NO
Do you have DISCOLORED teeth that bother you?	YES NO
Would you like your smile to LOOK BETTER or DIFFERENT?	YES NO

**MEDICAL HISTORY**

Are you under a PHYSICIAN'S CARE now?	For What?
NAME of physician providing care:	Telephone:
Have you been HOSPITALIZED recently or have you had any MAJOR OPERATIONS? Please explain:	
Have you ever had a serious INJURY to your HEAD or NECK?	Explain:
<b>What MEDICATIONS, PILLS, OR DRUGS are you taking?</b>	
<b>What MEDICATIONS OR SUBSTANCES are you ALLERGIC to?</b> (i.e., aspirin, penicillin, codeine, acrylic, metal, latex rubber, other, etc.)	

**CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:**

- |                               |                                |                                    |
|-------------------------------|--------------------------------|------------------------------------|
| Heart Disease/Attack          | Kidney Trouble                 | Venereal Disease                   |
| Heart Murmur                  | Renal Dialysis                 | Hepatitis A, B, or C (Circle Type) |
| Angina/Chest Pain             | Thyroid Disease                | Fever Blisters/Cold Sores          |
| Congenital Heart Disorder     | Arthritis/Rheumatism           | Nervousness/Panic Attacks          |
| Mitral Valve Prolapse         | Pain in Jaw Joint/TMJ Disorder | Psychiatric Care                   |
| Artificial Heart Valve        | Tuberculosis                   | Alzheimer's Disease                |
| Heart Surgery                 | Asthma                         | Pregnant/Trying to Get Pregnant    |
| Heart Pacemaker               | Emphysema                      | Cortisone Medications              |
| Rheumatic Fever               | Epilepsy/Seizures              | Smoker                             |
| Anemia                        | Dizziness/Fainting             | Drug Addiction                     |
| Stroke                        | Cancer                         | Sinus Trouble                      |
| High/Low Blood Pressure       | Chemotherapy                   | Codeine Allergy                    |
| Blood Transfusion             | Radiation Therapy              | Penicillin Allergy                 |
| Excessive Bleeding/Hemophilia | Glaucoma                       | List Other Allergies:              |
| Bruises Easily                | Stomach Problems/Ulcers        | _____                              |
| Sickle Cell Disease           | Artificial Joint/Prosthesis    | _____                              |
| Hypoglycemia                  | AIDS                           | _____                              |
| Diabetes                      | HIV Positive                   |                                    |
| Liver Trouble                 | Herpes                         |                                    |

Have you ever had another serious illness not listed above? Explain: \_\_\_\_\_

I acknowledge that all the preceding answers are correct, by my signature below. **If I have any changes in my health status, or if my medicines change, I will inform the dentist and staff at my next appointment, without fail.**

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_\_  
Date