

11. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or codeine	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/sedatives/sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies	<input type="checkbox"/>	<input type="checkbox"/>

12. Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Insulin/other diabetes drugs	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medicine	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis/other heart medications	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamine/allergy drugs/ cold remedies	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
			Other medication	<input type="checkbox"/>	<input type="checkbox"/>
			Over the Counter medications/nutritional supplements	<input type="checkbox"/>	<input type="checkbox"/>

Please list **name** of medication(s) and **dosage(s)** below:

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

13. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

14. Have you ever had any serious trouble associated with previous dental treatment? _____

15. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

16. Do you usually have your teeth numbed/put to sleep for dental treatment? _____

17. Have you ever used nitrous oxide gas for your dental treatment? _____

18. Are you satisfied with your past dental treatment? _____

Do you now have or have you ever had any significant history of the following?

MOUTH	YES	NO	TEETH	YES	NO
Have you had any injury to your face/jaws	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding, sore gums	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to sweets	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters, lips/mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to biting	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Food impaction	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/ lips	<input type="checkbox"/>	<input type="checkbox"/>	Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw	<input type="checkbox"/>	<input type="checkbox"/>	Shifting of teeth	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing jaw	<input type="checkbox"/>	<input type="checkbox"/>	Change in bite	<input type="checkbox"/>	<input type="checkbox"/>
			Mouth breather	<input type="checkbox"/>	<input type="checkbox"/>
			Sugar in diet	<input type="checkbox"/>	<input type="checkbox"/>

ORAL HYGIENE

	YES	NO	How often do you brush _____ Floss _____
Do you use the following?			
Brush	<input type="checkbox"/>	<input type="checkbox"/>	Brush is : Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard <input type="checkbox"/>
Dental floss	<input type="checkbox"/>	<input type="checkbox"/>	Electric <input type="checkbox"/>
Fluoride rinse	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____			

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 change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, _____

Parent, or Guardian _____ Date _____

Reviewer's Initials _____