

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

	YES	NO
Local anesthetics (e.g. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/sedatives/sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Aspirin or codeine	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Other allergies _____		

10. Are you taking any of the following?

	YES	NO
Antibiotics/sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medicine	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines/allergy drugs/ cold remedies	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin/other diabetes drugs	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis/other heart medications	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Other Medication _____		

If yes to any of the above, list **name** of medication and **dosage** below:

1. _____

2. _____

3. _____

4. _____

11. 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 _____

12. Physician's Name _____ Phone _____

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

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

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
If so, when? _____

17. Do you have or have you ever had any of the following?

MOUTH

	YES	NO
Bleeding, sore gums	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters, lips/mouth	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>
Ortho treatments (braces)	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/lips	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing jaw	<input type="checkbox"/>	<input type="checkbox"/>

TEETH

	YES	NO
Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to hot	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to sweets	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to biting	<input type="checkbox"/>	<input type="checkbox"/>
Food impaction	<input type="checkbox"/>	<input type="checkbox"/>
Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>
Shifting of teeth	<input type="checkbox"/>	<input type="checkbox"/>
Change in bite	<input type="checkbox"/>	<input type="checkbox"/>

ORAL HYGIENE

Do you use the following?	YES	NO
Brush	<input type="checkbox"/>	<input type="checkbox"/>
Dental floss	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride rinse	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

How often do you brush _____

Brush is: Soft Medium Hard

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 _____