



Patient Name (First and Last)

Name of Previous Dentist/Location

Date of Last Exam

Name of Physician/Location

Date of Last Exam

Are you allergic or have you reacted adversely to any of the following:

- Aspirin
- Penicillin
- Ibuprofen
- Barbiturates
- Local Anesthesia
- Codeine
- Erythromycin
- Sulfa Drugs
- Tetracycline
- Acetaminophen/Tylenol
- Nitrous Oxide
- Latex
- Other Antibiotics

Do you have any other allergies? If yes, please list:

Check any of the following that you HAVE HAD or HAVE at present:

- Heart Disease/Attack
- Stroke
- Hepatitis A
- Artificial Joints
- High Blood Pressure
- Kidney Trouble
- Hepatitis B
- Anemia
- Heart Murmur
- Hepatitis C
- Arthritis
- Rheumatic Fever
- Asthma
- Hemophilia
- AIDS or HIV
- Heart Pacemaker
- Diabetes
- Epilepsy/Seizures
- Heart Surgery
- Thyroid
- Psychiatric Treatment
- Liver Disease
- Chemotherapy
- Radiation Treatment
- Bleeding Disorder
- Drug/Alcohol Addiction
- Endocarditis
- Shortness of Breath
- Other: \_\_\_\_\_

Please explain any checked above:

YES / NO

- Have you been hospitalized during the past two years? Please explain: \_\_\_\_\_
- Have you been asked by your medical doctor to premedicate before any dental treatment?
- Have you been taking Pehn-Fen or appetite suppressants?
- Do you have any disease, condition or problems not listed? Please list: \_\_\_\_\_
- Do you smoke or use tobacco? If so, how often/which type: \_\_\_\_\_
- WOMEN ONLY: Are you pregnant? If pregnant, when is your due date? \_\_\_\_\_
- WOMEN ONLY: Are you taking birth control pills?    YES    NO

Please list any medications you are currently taking:



Continued from first page.

YES / NO

- Are you having any Dental pain or discomfort at this time?
- Do your gums bleed while brushing and flossing?
- Are your teeth sensitive to hot or cold liquids/foods?
- Are your teeth sensitive to sweet or sour liquids/foods?
- Have you ever experienced any of the following problems with your jaw?  
Please circle all that apply:      Clicking      Pain      Difficulty in Opening/Closing      Difficulty in Chewing
- Do you have frequent headaches?
- Do you clench or grind your teeth?
- Have you ever had any orthodontic treatment? (Braces)
- Do you wear a retainer?
- Do you wear dentures or partials? If so, date of placement?
- Do you have any concerns about bad breathe odor?
- Are you pleased with the appearance of your teeth when you smile?
- Are you pleased with the color of your teeth?
- Are there old fillings or dental treatment that you are not happy with?
- Are you nervous about dental treatment?

Please sign: I certify that all of the above information is true to the best of my knowledge.

Signature of patient (or parent)

Date