



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"/>	Latex allergy .....	<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		Yes	No
Antibiotics/sulfa drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines/allergy drugs,			Digitalis/other heart		
Blood thinners .....	<input type="checkbox"/>	<input type="checkbox"/>	cold remedies .....	<input type="checkbox"/>	<input type="checkbox"/>	medicines .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medicines .....	<input type="checkbox"/>	<input type="checkbox"/>	Anti depressants .....	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medicine .....	<input type="checkbox"/>	<input type="checkbox"/>	Insulin/other diabetes drugs ..	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids .....	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	Birth control .....	<input type="checkbox"/>	<input type="checkbox"/>
						Herbal supplements/ other .....	<input type="checkbox"/>	<input type="checkbox"/>

List names of medicine and dosage below:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
 3. \_\_\_\_\_ 4. \_\_\_\_\_

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

14. Have you ever had any serious trouble complications associated with previous dental treatment? If so, explain: \_\_\_\_\_

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

16. Date of last dental visit \_\_\_\_\_ last dental cleaning \_\_\_\_\_ how often \_\_\_\_\_  
 Date of last dental x-rays \_\_\_\_\_

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

18. Name of your previous dentist \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ How Long? \_\_\_\_\_

Please Circle the following you have or have had in the past 6 months:

**MOUTH**

- Bleeding, sore gums
- Unpleasant taste/bad breath
- Burning tongue/lips
- Frequent blisters, lips/mouth
- Swelling/lumps in mouth
- Clicking/popping jaw/clenching/grinding
- Difficulty opening or closing jaw
- Headache/earache/neck pain

**TEETH**

- Bad reaction to dental anesthetic, numbing
- Loose teeth
- Sensitive to hot
- Sensitive to cold
- Sensitive to sweets
- Food impaction
- Change in bite
- Numbness

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or change in my medication, I will inform the dentist at the next appointment.

\_\_\_\_\_  
 Signature of Patient, Parent or Guardian

\_\_\_\_\_  
 Date