

Medications

Please list all medications, including herbal and dietary Supplements you are presently taking.

Medications:

Purpose:

Please list all major surgeries or hospitalizations: _____

Allergies: Aspirin Barbiturates (sleeping pills) Codeine Iodine Latex

Local Anesthetic Penicillin Sulfa Other: _____

Do you wear contact lenses? Yes No

Dental History

Bad breath Yes No

Bleeding gums Yes No

Blisters on Lips or mouth Yes No

Burning sensation on tongue Yes No

Chew on one side of mouth Yes No

Cigarette/pipe/cigar smoker Yes No

Dry mouth Yes No

Fingernail biting Yes No

Food collection between teeth Yes No

Foreign objects Yes No

Grinding teeth Yes No

Gums swollen or tender Yes No

Jaw clicking or popping Yes No

Jaw pain or tiredness Yes No

Lip or cheek biting Yes No

Loose teeth/broken fillings Yes No

Mouth breathing Yes No

Mouth pain when brushing Yes No

Orthodontic treatment Yes No

Pain around ear Yes No

Periodontal treatment Yes No

Sensitivity to cold Yes No

Sensitivity to heat Yes No

Sensitivity to sweets Yes No

Sensitivity to biting Yes No

Sores or growths Yes No

How often do you floss? _____

How often do you brush? _____

To the best of my knowledge, all the above answers are true and correct. If I have any changes I will inform the dentist or hygienist at my next appointment.

Signature

Date

(To be completed by dentist)

Vital signs:

Blood Pressure: _____ Pulse: _____ Date: _____

ASA Classification: ASA I _____ ASA II _____ ASA III _____ ASA IV _____

Dentist Signature: _____