Are you taking any of the following?

YES	NO		YES	NO	
❑	❑	Antibiotics or sulfa drugs	❑	❑	Dilantin or other anti-convulsant
❑	❑	Anticoagulants (blood thinner)	❑	❑	Insulin, Tolbutamide, Orinase or other similar medication
❑	❑	Medicine for high blood pressure	❑	❑	Nitroglycerin
❑	❑	Medicine for high cholesterol	❑	❑	Alcohol Antabuse
❑	❑	Cortisone or steroids	❑	❑	Narcotic Analgesic
❑	❑	Tranquilizers	❑	❑	Aredia, Zometa, Actonel, Fosamax, Boniva, Didronel (or other bisphosphonate meds)
❑	❑	Anti-depressant medication			
❑	❑	Aspirin or anti-inflammatory agent			

What vitamins do you take? _____

What herbal or natural supplements do you take? _____

List all other medications that you are currently taking _____

_____

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you ever experienced any of the following problems in your jaw		
a) Clicking	❑	❑
b) Pain (joint, ear, and side of face)	❑	❑
c) Difficulty in opening or closing	❑	❑
d) Difficulty in chewing?	❑	❑
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you had any serious trouble associated with any previous dental treatment? Please explain.	❑	❑
13. Have you had any orthodontic work?	❑	❑
14. Have you been satisfied with your previous dental care?	❑	❑
15. Are you interested in keeping your teeth?	❑	❑

What is the reason for your visit today? _____

Date of last dental appointment and what was done _____

Do you brush, floss, or use any other dental aids? _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE _____ DATE

PATIENT, PARENT OR GUARDIAN