HEALTH HISTORY Continued…

Name: _____ Date of Birth: _____ Age: _____

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

Local anesthetics (novocaine) Yes ____ No ____
Barbiturates/sedatives/sleeping pills Yes ____ No ____
Penicillin/other antibiotics….. Yes ____ No ____
Aspirin or Codeine…….. Yes ____ No _____
Sulfa drugs ……. Yes ____ No _____
Other allergies …… Yes ____ No _____

Are you taking any of the following?

Antibiotics/Sulfa drugs…… Yes ____ No ____
Blood thinners ……. Yes ____ No ____
Blood Pressure medication… Yes ____ No ____
Thyroid medication…… Yes ____ No ____
Cortisone/steroids …… Yes ____ No ____
Antihistamines/allergy drugs/
Cold remedies……. Yes ____ No ____
Frequent nosebleeds …… Yes ____ No ____
Tranquilizers …….. Yes ____ No _____
Insulin/other Diabetes drugs … Yes ____ No _____
Recreational drugs …….. Yes ____ No _____
Digitalis/other heart medicines. Yes ____ No _____
Nitroglycerine …… Yes ____ No _____
Aspirin …….. Yes ____ No _____
Other Medications …… Yes ____ No _____
Arthritis/rheumatism …….. Yes ____ No _____

If you answered **"Yes"** to any of the above, please list **name of medication and dosage** below:

1. _____
2. _____
3. _____
4. _____

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, please explain: _____

_____

Physician's Name _____ Telephone # _____

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

_____

Does dental treatment make you nervous? …… No ___ Slightly _____ Moderately _____ Extremely _____

Date of your last dental visit: _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ……. Yes ____ No _____

If yes, when? _____

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

Mouth

Bleeding or sore gums……Yes ____ No ____
Unpleasant taste/bad breath …. …. Yes ____ No ____
Burning tongue/lips …….. Yes ____ No ____
Frequent blisters, lips/mouth …….. Yes ____ No ____
Swelling/lumps in mouth ……. Yes ____ No ____
Orthodontic treatments (braces). Yes ____ No ____
Biting cheeks/lips…… Yes ____ No ____
Clicking/popping jaw…….. Yes ____ No ____
Difficulty opening or closing jaw…. Yes ____ No ____

Teeth

Loose teeth …….. Yes ____ No ____
Sensitivity to hot …… Yes ____ No ____
Sensitivity to cold …….. Yes ____ No ____
Sensitivity to sweets …… Yes ____ No ____
Sensitivity to biting …… Yes ____ No ____
Food stuck in-between teeth ……. Yes ____ No ____
Clenching/grinding …… Yes ____ No ____
Shifting of teeth…….. Yes ____ No ____
Change in bite …… Yes ____ No ____

Oral Hygiene

How often do you brush? …….. Never_____ once per day____ twice per day____ three times+ per day _____
How often do you floss? …….. Never_____ once per day____ twice per day____ three times+ per day _____
How often do you rinse? …….. Never_____ once per day____ twice per day____ three times+ per day _____
Type of mouthrinse? …… Antiseptic (ie Listerine)_____ Fluoride _____ Whitening _____ Freshen breath _____
Bristle softness of toothbrush (electric or manual)…… Extra Soft _____ Soft _____ Medium _____ Firm _____

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 in my medication(s), I will inform the dentist at my next appointment. _____

Signature (Patient, Parent or Guardian) Date