Medications

Please list all the medications you are presently taking Medications:	including any herbal and dietary supplements: 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	Gums swollen/tender	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Jaw pain/tiredness	☐ Yes ☐ No
Blisters on lips/mouth	☐ Yes ☐ No	Lip/cheek biting	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Loose teeth/broken fillings	☐ Yes ☐ No
Chew on one side Of mouth	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Cigarette pipe/cigar Smoker	☐ Yes ☐ No	Mouth pain/brushing	☐ Yes ☐ No
Clicking or popping Jaw	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Dry Mouth	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
Fingernail biting	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Food collection between Teeth	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
Foreign objects	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
		Sensitivity to biting	☐ Yes ☐ No
		Sores/growths mouth	☐ 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. I understand there will be a $25.00 broken appointment fee if I fail to give 24 hours notice.

_____

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:_____**Date:**_____