

Medications

List any medications you are currently taking and the correlating diagnosis:

Allergies

- | | |
|--------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | |

Pharmacy

Pharmacy name: _____ Location: _____

Phone Number: _____

Dental History

Reason for today's visit _____

General Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | |
|-----------------------------------|----------------------------------------------------------|---------------------------------|----------------------------------------------------------|
| Bad breath: | <input type="checkbox"/> yes <input type="checkbox"/> no | Lip or cheek biting: | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bleeding gums: | <input type="checkbox"/> yes <input type="checkbox"/> no | Loose teeth or broken fillings: | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Blister on lips or mouth: | <input type="checkbox"/> yes <input type="checkbox"/> no | Mouth pain, brushing: | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Burning sensation on tongue: | <input type="checkbox"/> yes <input type="checkbox"/> no | Orthodontic treatment: | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chew on one side of mouth: | <input type="checkbox"/> yes <input type="checkbox"/> no | Pain around ear: | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Cigarette, pipe, or cigar smoker: | <input type="checkbox"/> yes <input type="checkbox"/> no | Periodontal treatment: | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Clicking or popping jaw | <input type="checkbox"/> yes <input type="checkbox"/> no | Hot/Cold sensitivity: | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Dry mouth: | <input type="checkbox"/> yes <input type="checkbox"/> no | Sensitivity to sweets: | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Food collection between teeth: | <input type="checkbox"/> yes <input type="checkbox"/> no | Sores or growths in your mouth: | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Foreign objects: | <input type="checkbox"/> yes <input type="checkbox"/> no | How often do you floss? _____ | |
| Grinding teeth: | <input type="checkbox"/> yes <input type="checkbox"/> no | How often do you brush? _____ | |
| Gums swollen or tender: | <input type="checkbox"/> yes <input type="checkbox"/> no | | |
| Jaw pain or tiredness: | <input type="checkbox"/> yes <input type="checkbox"/> no | | |