

Patient Name _____ Name you like to be called _____

Please list medications you are taking: _____

Medical Doctors _____

Check if you have ever had the following:

1. Allergic or Adverse Reaction to medication

- | | | |
|---------------------------------------|--|---------------------------------|
| <input type="checkbox"/> aspirin | <input type="checkbox"/> local anaesthetic | <input type="checkbox"/> latex |
| <input type="checkbox"/> penicillin | <input type="checkbox"/> fluoride | <input type="checkbox"/> metals |
| <input type="checkbox"/> erythromycin | <input type="checkbox"/> codeine | <input type="checkbox"/> other |

2. Heart Problems

- | | | |
|--|--|---|
| <input type="checkbox"/> murmur | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> pacemaker |
| <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> anemia |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> stroke | <input type="checkbox"/> prolonged bleeding |

3. Communicable Diseases

- | | |
|---|--|
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> acquired immune deficiency syndrome |
| <input type="checkbox"/> hepatitis type _____ | <input type="checkbox"/> jaundice |

4. Respiratory conditions asthma emphysema other use tobacco products

5. Women - Are you pregnant? Due Date _____

6. Please list any past or current medical conditions you may have that are not listed above _____

7. What is your immediate Dental concern? _____

8. Jaw Problems (temporomandibular joint)

- | | |
|---|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> clench or grind your teeth |
| <input type="checkbox"/> difficulty opening your mouth widely | <input type="checkbox"/> jaw clicking |
| <input type="checkbox"/> stiff neck muscles | <input type="checkbox"/> awaken with an awareness of your jaw or teeth |

9. Concerns with your gums or teeth

- If you could change anything about your smile, what would it be? _____

- | | |
|---|---|
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> unfavorable dental experiences |
| <input type="checkbox"/> sensitive to temperature | <input type="checkbox"/> dental fears |
| <input type="checkbox"/> sore teeth | |

10. Can you tell us what caused you to leave your last dental office? _____

11. What is important to you when you start going to a new dentist? _____

12. What can we do to help you feel comfortable at our office? _____

Patient's Signature _____ Date _____