

DENTAL HISTORY

NAME _____

Do you presently have any pain or concerns with your mouth? Please describe:

- Do you clench or grind your teeth? Have you ever injured your face or jaw?
- Has your jaw ever locked opened? Do you have difficulty opening your mouth wide?
- Does your jaw tire when you chew? Does your jaw click or pop?
- Are your jaw and temple muscles tender when you press on them?
- Do you snore? Do you wake up tired? Do you feel the need to take naps?
- Do any teeth feel loose?
- Do you have any food traps (food impaction between teeth)?
- Do your gums bleed when you brush?
- Have your gums ever been treated?
- Do you presently have mouth ulcers?
- Are you allergic to latex?
- Are any of your teeth sensitive to? Heat Cold Biting Pressure Sweets

MEDICAL HISTORY

Do you have any general health problems? Please elaborate:

Are you currently being treated by a physician for a medical condition? Please elaborate:

Physician _____ Phone _____

- Have you been hospitalized within the past two years? _____
- Are you allergic to any drugs or medications? _____

Do you smoke or use oral tobacco products? Please elaborate: _____

Are you currently taking any drugs or medications? If yes, please list: _____

*** Please note the use of recreational drugs can interact adversely with our use of Xylocaine (Novocain) ***

Do you have any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Night sweats/fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart attack/angina |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors or Cancer |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Endocrine Disease | <input type="checkbox"/> Unusual weight Loss |
| <input type="checkbox"/> Acquired Immunodeficiency Disease/Other Venereal Disease | | |

WOMEN ONLY: Are you pregnant or is there a possibility that you may be pregnant? _____

**** CHANGES **:** Home Address: _____

Contact Telephone Number: _____

Email Address: _____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT AND VALID

Signature _____

Date _____