PATIENT NAME________________________________ TODAY'S DATE______/______/______

DENTAL HISTORY CONTINUED

Please check if you have or had:

- ❑ Bad breath
- ❑ Blisters on lips or mouth
- ❑ Burning sensation on tongue
- ❑ Cigarettes, pipe, cigars, chew
- ❑ Vapor cigarettes/Vaping
- ❑ Dry mouth
- ❑ Food collects between teeth
- ❑ Clench or grind teeth
- ❑ Growths or sore spots
- ❑ Swollen gums, bleeding
- ❑ Lip or cheek biting
- ❑ Mouth breathing
- ❑ Orthodontic treatment
- ❑ Periodontal treatment
- ❑ Sensitivity to hot, cold, sweets
- ❑ Loose or broken teeth/fillings

Have you ever had an allergic reaction to Novocaine, local or general anesthetics? ❑ Yes ❑ No

Have you ever had any abnormal bleeding from an extraction or any type of surgery? ❑ Yes ❑ No

Women- Are you:

Pregnant/Trying to get pregnant? ❑ Yes ❑ No

Taking oral contraceptives? ❑ Yes ❑ No

Nursing? ❑ Yes ❑ No

MEDICAL HISTORY

Physician's name:_______________________ Phone: ________________ Date of last visit____________

Are you under a physician's care now? ❑YES ❑NO If yes,please explain:________________________________

Have you ever been hospitalized or had a major operation? ❑YES ❑ NO ________________________________

ARE YOU ALLERGIC TO? ❑ **Aspirin** ❑ **Codeine** ❑ **Penicillin** ❑ **Latex** ❑ **Metal** ❑ **Acrylic** ❑ **Other**__________

Please attach list or fill in box below for all MEDICATIONS: Prescription and Non Prescriptions

____________	____________	____________
____________	____________	____________
____________	____________	____________

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

- ❑ Acid Reflux
- ❑ ADD/ADHD
- ❑ AIDS/HIV Positive
- ❑ Alcohol Dependency
- ❑ Alzheimer's
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Anorexia/Bulimia
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint-Year_______
- ❑ Asperger's Syndrome
- ❑ Asthma
- ❑ Autism
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer-Type ___________
- ❑ Chemotherapy
- ❑ Chest Pains/Angina
- ❑ Colitis/Crohn's/IBS
- ❑ Congenital Heart Condition
- ❑ Dementia
- ❑ Depression/Anxiety
- ❑ Diabetes/diet-oral medication
- ❑ Diabetes/insulin dependent
- ❑ Drug Addiction
- ❑ Easily Winded/Fatigued
- ❑ Emphysema/ COPD
- ❑ Epilepsy or Seizures
- ❑ Epstein- Barr
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Fever Blisters
- ❑ Frequent Cough
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Heart Attack/Failure (CHF)
- ❑ Heart Murmur
- ❑ Heart Pace Maker
- ❑ Heart Problems/Disease
- ❑ Hemophilia
- ❑ Hepatitis Type_____
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ HPV/STDs
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Lyme Disease
- ❑ Lymphedema/Lipedema
- ❑ Mitral Valve Prolapse
- ❑ Narcolepsy/ Cataplexy
- ❑ Nerve Pain/ Damage
- ❑ Pain in Jaw/ Joints
- ❑ Parkinson's
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Extreme Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Sleep Apnea
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Trigeminal Neuralgia
- ❑ Ulcers
- ❑ Yellow Jaundice
- ❑ Other Conditions not listed______________________________

AUTHORIZATION AND RELEASE

I have read the above questions and have answered them accurately to the best of my knowledge. I understand that providing incorrect information can dangerous for my health when undergoing any medical or dental procedures. I hereby authorize Dr. Paper or designated staff to perform necessary dental treatment that is mutually agreed upon by me.

Signature____Date____________________