

Please list any medications you are currently taking:

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

- 7. _____ 8. _____
- 9. _____ 10. _____
- 11. _____ 12. _____

Women: Are you pregnant? No Yes
 If no, are you planning a pregnancy in the near future? No Yes
 Are you a nursing mother? No Yes
 Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
 Have you ever received a diagnosis of "high blood pressure"?
 What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:

- a. Local anesthetics No Yes
- b. Penicillin or other antibiotics No Yes
- c. Aspirin, Ibuprofen or Tylenol No Yes
- d. Codeine, Valium® or other sedatives..... No Yes
- e. Latex or Metals
- f. Other (please specify) _____
- g. Foods _____

Do you have dry mouth..... No Yes
 Reason _____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes
Do you use any recreational drugs?	No	Yes

Previous Dentist _____ Last visit there: _____

Phone # _____ Are Recent x-rays available? _____

Is there anything bothering you that you want the Doctor to look at? _____

How do you feel about your smile _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

I will allow the Doctor to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures and further will allow him permission to discuss my conditions with my physician and to request medical information from him/her.

 Patient (Print Name) Patient Signature Date