





## HEALTH HISTORY CONTINUED

YES NO

20. Have you had chemotherapy, radiation (X-Ray) treatment or IV bisphosphonates for a tumor, growth or other condition?
21. Are you taking any of the following medications, herbal supplements, diet supplements, and if so, for what conditions?
- a. Antibiotics or sulfa drugs
  - b. Heart medications
  - c. Steroids (cortisone)
  - d. Nonsteroidal anti-inflammatory medication (Aspirin, Ibuprofen, Naproxen sodium, etc.)
  - e. Insulin
  - f. Antihistamines
  - g. Dilantin
  - h. Oral contraceptives or other hormonal therapy
  - i. Antidepressants
  - j. Bisphosphonates (ie. Fosamax, etc) \_\_\_\_\_
  - k. Other \_\_\_\_\_
22. Are you allergic or have you reacted adversely to:
- a. Local anesthetics (Novacaine, Xylocaine)
  - b. Penicillin, Amoxicillin, Augmentin, or any other antibiotic
  - c. Sulfa drugs, sulfites
  - d. Barbituates (sedatives, sleeping pills)
  - e. Valium
  - f. Aspirin, Ibuprofen
  - g. Codeine, Vicodin (Hydrocodone) or other narcotics
  - h. Other \_\_\_\_\_
23. Have you ever been under psychiatric treatment?
24. Do you consider yourself a nervous person?
25. Do you often feel unhappy and depressed?
26. Any history of anxiety or panic attacks?
27. Are you easily upset or irritated?
28. Do you have any disease, condition or other problem not listed here that you think I should know about?

### WOMEN

29. Are you pregnant or nursing at the present time?
30. Are you trying to become pregnant?
31. Are you currently going through or have you completed menopause?

### DENTAL HISTORY

1. Have you been to a dentist in the past 2 years? If not how long? \_\_\_\_\_
2. Have you had a complete set of X-Rays taken in the past 5 years?
3. Have you had orthodontic treatment?
4. Do you think that your teeth are affecting your general health in any way?
5. Are you dissatisfied with the appearance of your teeth or smile?
6. Are you worried about receiving dental treatment?
7. Do you have difficulty in chewing your food? If so, what are your specific concerns?
8. Do you have sensitive teeth?
9. Do you have bleeding gums?
10. Have you been aware of a bad taste or odor in your mouth?
11. Have you ever had sores in the mouth or on the lips that were slow to heal?
12. Do you have difficulty in opening your mouth wide?
13. Does your jaw joint (TMJ) click or pop?
14. Do your jaw muscles ever get tired or ache?
15. Do you clench or grind your teeth during the day or night?
16. Have you ever had an injury to your face or jaws?
17. Do you have a dry mouth?
18. Are you satisfied with the quality of dental care you have been receiving?
19. Why are you now seeking dental treatment? \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date