13. Are you allergic or have experienced allergic reaction to any of the following? (circle all that apply)

* Local anesthetics (e.g. novocaine) YES NO
* Penicillin/other antibiotics YES NO
* Sulpha drugs YES NO
* Barbiturates/sedatives/other sleeping pills YES NO
* Iodine YES NO
* Latex, rubber gloves/dam YES NO
* Aspirin YES NO
* Codeine or any other narcotics YES NO
* Other__________________

14. Are you taking or using any of the following? (circle all that apply)

* Antibiotics/sulfa drugs YES NO
* Blood thinners YES NO
* Aspirin YES NO
* Blood pressure medication YES NO
* Digitalis/other heart drugs YES NO
* Nitroglycerin YES NO
* Insulin/other diabetes drugs YES NO
* Cortisone/steroids YES NO
* Thyroid medicine YES NO
* Antithistamenes/allergy medications YES NO
* Recreational drugs YES NO
* Other__________________

Have you ever taken or taking now Phenphen YES NO

Have you ever taken or taking now **Bisphosphanates** (ex: Fosamax) YES NO

If yes to any of the above, list name of medication and dosage below:

____

____

____

15. Do you have any disease, condition, or problem not listed above that you should tell the dentist? YES NO

Please Explain: ____

____

16. Do you have or have you ever had any of the following

* Dental pain YES NO
* Bleeding gums/periodontal disease YES NO
* Blisters/ulcers/cold sores YES NO
* Swelling/lumps in mouth YES NO
* White coating on tongue YES NO
* Problem with tonsils/adenoids YES NO
* Clicking/popping jaw YES NO
* Difficulty opening/closing YES NO jaw YES NO
* Pain in or near ears YES NO
* Sinus trouble YES NO
* Injury to face/jaw YES NO
* Surgery to face/jaw YES NO
* Loose teeth YES NO
* Sensitive teeth YES NO
* Clenching/grinding teeth YES NO
* Shifting of teeth YES NO
* Dissatisfied with appearance of teeth YES NO
* Ortho treatments braces) YES NO
* Other__________________

17. Are you interested in a screening appointment in the Orthodontic (braces) Clinic? *YES NO*

17. Does dental treatment makes you **nervous**? YES NO

18. Have you had difficulties with past dental treatment? YES NO

Please Explain: ____

I think I need implant to :(Check all that applies and explain.)

1- Eat Better__________ 2- Look Better__________ 3- Speak Better__________ 4- Get rid of Dentures__________

Sleep Questionnaire

1. Do you snore? Don't know Yes No
2. Is your snoring interrupted by pauses or choking? Yes No
3. Has anyone ever said that you stop breathing or gasp during your sleep? Yes No
4. Do you often feel fatique, exhausted or tired? Yes No
5. Do you wake up during the night or in the morning with headaches? Yes No
6. Have you ever nodded off or fallen asleep while driving? Yes No

Do you have any concerns? : ____

I certify that to the best of my knowledge the above information complete and accurate.

If there are any changes in my health, or medicines, I will inform my dentist at the next appointment visit.

Patient signature ______________________________ ***Date***____________

Doctor signature ______________________________ ***Date***____________

##

Medical/Dental history update (done at each recall visit):

Date	*Comments*	*Patient Signature*