DENTISTS OF OVERLAND PARK

Allergies (check all that apply)

- ☐ None
- ☐ Aspirin
- ☐ Codeine
- ☐ Epinephrine
- ☐ Amoxicillin/Penicillin
- ☐ Preservatives
- ☐ Sulfa
- ☐ Erythromycin
- ☐ Fragrances
- ☐ Iodine
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Tetracycline
- ☐ Medication Allergy: _____
- ☐ Medication Allergy: _____
- ☐ Other: _____

***Health history* (check all that apply)**

- ☐ None
- ☐ Acid Reflux
- ☐ AIDS/HIV Positive
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis (severe allergic reaction)
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis_____
- ☐ Artificial Heart/Valves
- ☐ Artificial Joints_____
- ☐ Asthma
- ☐ Autism
- ☐ Auto Immune_____
- ☐ Birth Control_____
- ☐ Blood Disease
- ☐ Cancer_____
- ☐ Chemotherapy_____
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Headaches/Chronic Migraines
- ☐ Heart Disease, Congenital
- ☐ Heart Murmur
- ☐ Hepatitis Type_____
- ☐ Herpes Type_____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Mouth Breathing
- ☐ Major Surgery _____
- ☐ Pacemaker
- ☐ Pregnancy (currently)
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Sinus Problems
- ☐ Smoker
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ Problems
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors_____
- ☐ Ulcers
- ☐ Venereal Diseases
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

***Medications* (current)** _____

_____

Anything else that you need/want us to know? _____

_____

***Dental history* (check all that apply)** **Last Dental Visit:** _____

- ☐ A desire to replace missing teeth?
- ☐ Injury to mouth/teeth
- ☐ Clenching/Grinding
- ☐ Misaligned Teeth
- ☐ Unfavorable dental experiences
- ☐ Sensitive to cold, hot, sweet, or pressure?
- ☐ Food Impaction
- ☐ Swelling or sores in your mouth?
- ☐ Periodontal treatment
- ☐ Electric Toothbrush & brand _____
- ☐ Floss ____x/week
- ☐ Manual Toothbrush

Patient Signature _____

Printed Name _____ Date: _____