	YES	NO
27. Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?	☐	☐
28. Are you in general good health at this time?	☐	☐
29. Have any wounds healed slowly or presented other complications?	☐	☐
30. Are you pregnant?	☐	☐
31. Do you have a history of fainting or seizures?	☐	☐
32. Have you ever had any X-RAY TREATMENTS (other than diagnostic)?	☐	☐

PATIENT DENTAL HISTORY

33. Do you have sensitivity to Hot, Colds, or Sweets?	☐	☐
34. Do you have pain in or near your ears?	☐	☐
35. Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
36. Have you experienced any growth or sore spots in your mouth?	☐	☐
37. Does any part of your mouth hurt when clenched?	☐	☐
38. Have you ever had Novocaine anesthetic?	☐	☐
39. Any reactions or allergic symptoms to Novocaine?	☐	☐
40. Any difficult extractions in the past?	☐	☐
41. Prolonged bleeding following extractions in the past ?	☐	☐
42. Trench mouth?	☐	☐
43. Do you have an unpleasant odor or taste in your mouth?	☐	☐
44. Do your gums bleed?	☐	☐
45. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
46. Have you ever had instructions on the care of your gums?	☐	☐
47. Do you chew on only one side of your mouth? If so, why?	☐	☐
48. Do you at the present time have any dental complaints?	☐	☐
49. Do you habitually clench your teeth during the night or day?	☐	☐

50. When was your last full mouth X-RAY taken? _____Where?_____

51. Is any part of your mouth sore to pressures or irritants (cold, sweets, etc.)?

If so, locate_____

Patient Signature_____ **Date**_____