Compassionate Dentistry, P.C.
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Medication Listing

It is important that we have an accurate listing of all of the medications you are currently taking to provide dental health care to you in a safe and efficient manner. Please list below or bring accurate copy of current medications. Check Box below if bringing list.

Please take this information from your prescription bottle label.

☐ See photo copy list of medication.

Medication name	Strength (mg or units)	Dosing Instructions	Prescribing Doctor

Over the Counter Medications, Herbal Products & Vitamins

Product Name	Strength (mg or units)	Amount & how often taken

	YES	NO
1. Do you have any dental problems now?	[ ]	[ ]
2. Do you have any teeth that are sensitive to hot or cold?	[ ]	[ ]
3. Have you ever had:		
a. Orthodontic Treatment?	[ ]	[ ]
b. Oral Surgery?	[ ]	[ ]
c. Periodontal Treatment?	[ ]	[ ]
d. Your teeth ground or the bite adjusted?	[ ]	[ ]
e. Worn a bite plate or other appliance?	[ ]	[ ]
4. Have you noticed any loosening of your teeth?	[ ]	[ ]
5. Does food tend to become caught between your teeth?	[ ]	[ ]
6. Do you suffer from pain and/or swelling of your gums?	[ ]	[ ]
7. Do your gums often bleed when you brush your teeth?	[ ]	[ ]
8. Have your parents experienced gum disease?	[ ]	[ ]
9. Problems of the jaw. Have you experienced:		
a. Clicking of the jaw?	[ ]	[ ]
b. Pain (joint, ear, side of face)?	[ ]	[ ]
c. Difficulty in opening or closing?	[ ]	[ ]
d. Difficulty in chewing?	[ ]	[ ]

	YES	NO
10. Habits Do you:		
a. Clench or grind your teeth while awake or asleep?	[ ]	[ ]
b. Bite your lips or cheeks regularly?	[ ]	[ ]
c. Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)?	[ ]	[ ]
d. Mouth breathe while awake or asleep?	[ ]	[ ]
e. Use hard candy or chew gum?	[ ]	[ ]
11. Number of 12 oz. Soft drinks per day?_____ Brand?_____		
12. Do you feel very nervous about having dental treatment?	[ ]	[ ]
13. Have you ever had an upsetting experience in a dental office?	[ ]	[ ]
14. Are you dissatisfied with the appearance of your teeth?	[ ]	[ ]
15. Is there anything else about having dental treatment that bothers you?	[ ]	[ ]

Explanation:_____

_____

16. What can we do to make your visits more enjoyable?_____

_____