

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PLEASE LET US KNOW HOW YOU HEARD ABOUT US.

- | | | |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> FRIEND/RELATIVE _____ | <input type="checkbox"/> SIGNAGE | <input type="checkbox"/> ADVERTISING |
| <input type="checkbox"/> INSURANCE COMPANY | <input type="checkbox"/> YELLOW PAGES | <input type="checkbox"/> WEB SITE |
| <input type="checkbox"/> OTHER _____ | | |

DENTAL HEALTH INFORMATION

Thank you for providing us with important information that will help us serve you better.

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Are you having any discomfort? | <input type="checkbox"/> | <input type="checkbox"/> | Is the brightness of your teeth important to you? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any sensitivity to hot, cold, sweets, chewing? | <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke or use tobacco in any form? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does dental treatment make you nervous? | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink coffee or tea? | <input type="checkbox"/> | <input type="checkbox"/> |

Have you experienced any of the following problems:

- | | YES | NO |
|-----------------------|--------------------------|--------------------------|
| Bleeding gums | <input type="checkbox"/> | <input type="checkbox"/> |
| Bad breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Soreness in jaw joint | <input type="checkbox"/> | <input type="checkbox"/> |
| Grinding of teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| Snoring | <input type="checkbox"/> | <input type="checkbox"/> |

If I could change my smile I would make my teeth:

- | | YES | NO |
|--|--------------------------|--------------------------|
| Whiter | <input type="checkbox"/> | <input type="checkbox"/> |
| Straighter | <input type="checkbox"/> | <input type="checkbox"/> |
| Close space | | |
| Replace black mercury fillings with tooth colored restorations | <input type="checkbox"/> | <input type="checkbox"/> |
| Repair chipped teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace missing teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| Less gum showing | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace old crowns or caps that don't match | <input type="checkbox"/> | <input type="checkbox"/> |

On a scale of 1 to 10 with 10 being the highest rating:

CIRCLE ONE

- How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
- Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
- Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

- | | YES | NO |
|-----------------------------------|--------------------------|--------------------------|
| Do you prefer to save your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|--|--------------------------|--------------------------|
| Do you think your dental health effects your overall health? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|---|--------------------------|--------------------------|
| Have you ever had a special coating applied to your back teeth to protect from tooth decay? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|--|--------------------------|--------------------------|
| Do you think it is important to have your teeth cleaned at least every six months? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|------------------------------------|--------------------------|--------------------------|
| Do you take a fluoride supplement? | <input type="checkbox"/> | <input type="checkbox"/> |

When was the last time you had an oral cancer exam? _____ Date of last cleaning: _____

If there were a way to whiten your teeth for a very reasonable investment, would you be interested? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____