Medical Health

What would you consider your general health to be? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Primary Care Physician Name: ______________________________ Physician Phone #: ____________________

When was your last complete physical/check-up? ____

Are you taking any medication? Yes ☐ No ☐

Medication: ______________________________________ For what purpose? ______________________

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Do you have or have you ever had:

Heart Disease Yes ☐ No ☐
Rheumatic Fever Yes ☐ No ☐
Abnormal Blood Pressure Yes ☐ No ☐
Ulcers Yes ☐ No ☐
Diabetes Yes ☐ No ☐
Epilepsy/Seizures Yes ☐ No ☐
Anemia Yes ☐ No ☐
Congenital Heart Lesions Yes ☐ No ☐
Kidney Disease Yes ☐ No ☐
Frequent Headaches Yes ☐ No ☐
HIV-positive Yes ☐ No ☐
Cancer/Radiation Treatment Yes ☐ No ☐
Angina (Chest Pain) Yes ☐ No ☐
Tumors Yes ☐ No ☐
Substance Abuse Problems Yes ☐ No ☐
Mental Disability/Mental Illness Yes ☐ No ☐

Tuberculosis or Lung Disease Yes ☐ No ☐
Heart Murmur Yes ☐ No ☐
Asthma or Hay Fever Yes ☐ No ☐
Sinus Trouble Yes ☐ No ☐
Hepatitis Yes ☐ No ☐
Liver Disease Yes ☐ No ☐
Arthritis Yes ☐ No ☐
Stroke Yes ☐ No ☐
Glaucoma Yes ☐ No ☐
Pacemaker Yes ☐ No ☐
AIDS Yes ☐ No ☐
Joint Replacements Yes ☐ No ☐
Dry Mouth Yes ☐ No ☐
Dementia/Alzheimer's Disease Yes ☐ No ☐
Organ Transplant Yes ☐ No ☐
Osteoporosis Yes ☐ No ☐

Are you allergic to: Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Local Injected Anesthetics ☐ Iodine ☐ Metals/Nickel ☐
Aspirin ☐ Ibuprofen ☐ Latex or Plastics ☐ Any Other Medications/Materials? ____________________

Do you take antibiotics prior to dental treatment? Yes ☐ No ☐
Are you subject to prolonged bleeding? Yes ☐ No ☐
Do you have excessive urination and/or thirst? Yes ☐ No ☐

Do you use tobacco products? Yes ☐ No ☐
Are you taking any blood thinners? Yes ☐ No ☐
Are you subject to fainting spells? Yes ☐ No ☐

Have you ever had or are you currently getting IV Zoledronic Acid Treatments (such as Zometa or Reclast)? Yes ☐ No ☐

Have you had any major surgeries? Year: ______ Type of Surgery: ______________ Year: _______ Type of Surgery: ____________

Do you have any other medical problems not listed? Yes ☐ No ☐ If yes explain: ______________________________

Women: Are you or could you be pregnant? Yes ☐ No ☐ If yes, Due Date? _______________Are you nursing? Yes ☐ No ☐

Appliances: Do you use a Night Guard? Yes ☐ No ☐ Do you use a Sleep Apnea Device or Snore Guard? Yes ☐ No ☐

Dental Health

Reason for your visit today: ____________________________ When was your last dental visit? __________________

Have you ever had any serious problem associated with previous dental treatment? Yes ☐ No ☐

If yes, explain: ____

Are you experiencing any tooth, mouth, or jaw pain? Yes ☐ No ☐ Explain: ____________________________

Do you avoid brushing any part of your mouth because of pain? Yes ☐ No ☐ Explain: _____________________

How often do you brush your teeth? ____________________ How often do you floss? ___________________________

What type/texture toothbrush do you use? Soft ☐ Medium ☐ Hard ☐ Nylon ☐ Natural ☐

Do your gums bleed when brushing? Yes ☐ No ☐ Do your gums bleed when flossing? Yes ☐ No ☐

Do you use an electric toothbrush and/or WaterPik? Yes ☐ No ☐

Overall, are you satisfied with the appearance of your teeth? Yes ☐ No ☐

Would you like to talk with us about making your teeth straighter? Yes ☐ No ☐

Would you like your teeth to be whiter? Yes ☐ No ☐