

EXCEPTIONAL COSMETIC AND ADULT DENTISTRY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M  / F

**For the following questions check yes or no, whichever applies. Your answers are for our records only and will be considered confidential.**

<p>1. Are you in good health? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>2. Has there been any change in your health in the past year? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>3. My last physical exam was on _____</p> <p>4. Are you now under the care of a physician? Y <input type="checkbox"/> N <input type="checkbox"/> If so for what condition? _____</p> <p>5. Name of Physician _____ Address _____</p> <p>6. Have you had any serious illness, operation or hospitalization within the past 5 years? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>7. Are you taking medicine(s) including non-prescription, homeopathic, or "natural" remedies including diet pills? Y <input type="checkbox"/> N <input type="checkbox"/> If so please list _____</p> <p>8. Do you require pre-medication with antibiotics prior to dental appointments? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>9. Do you have or have you had any of the following diseases or problems?</p> <p>a. Damaged heart valves, artificial valves, heart murmur Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>b. Rheumatic Fever Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis, or any other heart condition Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>    1. Chest pain upon exertion? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>    2. Shortness of breath after mild exercise? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>    3. Do your ankles swell? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>    4. Do you have a pacemaker? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>    5. Do you have any pins/plates, artificial joints, or shunts placed? Y <input type="checkbox"/> N <input type="checkbox"/> If yes when? _____ Physician: _____ Phone: _____</p> <p>d. Seasonal allergies/ Hives Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>e. Sinus trouble Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>f. Asthma or hay fever Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>g. Fainting spells or seizures Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>h. Diabetes Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>i. Hepatitis, jaundice or liver disease Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>j. Frequent or recurring mouth sores Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>k. Thyroid problems Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>l. Respiratory problems, emphysema, bronchitis, etc Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>m. Arthritis or painful, swollen joints including jaw joint (TMJ) Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>n. Stomach ulcer or hyperacidity Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>o. Kidney trouble Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>p. Tuberculosis Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>q. Persistent cough or cough that produces blood Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>r. Persistent swollen neck glands Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>s. Low blood pressure or high blood pressure Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>t. Epilepsy or neurological disorder Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>u. Cancer Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>v. Any disease, drug or transplant operation that has depressed your immune system Y <input type="checkbox"/> N <input type="checkbox"/></p>	<p>10. Have you had abnormal bleeding? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>a. Have you ever required a blood transfusion? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>11. Do you have any blood disorder such as anemia? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>12. Have you ever had treatment for a tumor or growth? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, what type of treatment _____</p> <p>13. Are you allergic to or have you had a reaction to:</p> <p>a. Local anesthetics Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>b. Penicillin or antibiotics Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>c. Sulfa drugs or sulfide Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>d. Barbiturates or sleeping pills Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>e. Aspirin Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>f. Iodine Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>g. Codeine or other narcotics Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>h. Latex or rubber products Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>i. Other Y <input type="checkbox"/> N <input type="checkbox"/> If Yes please describe your symptoms/ reaction _____</p> <p>14. Have you had any serious trouble associated with previous dental treatment? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>15. Do you have any other condition or disease you think the doctor should know about? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>16. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for osteoporosis, chemotherapy or multiple myeloma, etc.)? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>17. Are you wearing contact lenses? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>18. Are you wearing removable dental appliances? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>19. Do you wish to talk with the doctor privately about anything? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>20. Do you smoke? Have you smoked or chewed tobacco? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>21. Have you had treatment for drug or alcohol abuse? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>22. Do you have or have you had any of the following symptoms:</p> <p>a. Headaches or migraines Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>b. Facial pain Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>c. Neck/ shoulder pain Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>d. Tinnitus/ Ringing in the ears Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>e. Worn or cracked teeth Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>f. Unexplained loose teeth Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>g. Sensitive or sore teeth Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>h. Jaw Pain Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>i. Numbness in fingers or arm Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>j. Clicking or popping in the jaw joints Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>k. Limited jaw movement or locking jaw Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>WOMEN:</b></p> <p>23. Are you pregnant or trying to become pregnant? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>24. Are you nursing? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>25. Are you taking birth control pills? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fully Explain any answered "Yes" above _____</b></p>
---	--

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

Date: \_\_\_\_\_

Patients Signature \_\_\_\_\_