

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phenfermine combination)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking or scheduled to begin taking either of the medications, atenolone (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date Treatment began:			

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
 Date: _____ If yes, have you had any complications? Yes No DK

Allergies - Are you allergic to or have you had a reaction to: Yes No DK
 To all yes responses, specify type of reaction.

Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfu drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK
 Name of physician or dentist making recommendation: _____
 Do you have any disease, condition, or problem not listed above that you think I should know about? _____
 Please explain: _____
 Phone: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

SMILE ANALYSIS

- Do you feel uncomfortable or self-conscious about your smile? Yes No
- Do you cover your mouth when you talk or smile? Yes No
- Would you like whiter teeth? Yes No
- Do you like the shape of your teeth? Yes No
- Do you have spaces between your teeth that bother you? Yes No
- Are your teeth too crowded? Yes No
- Can you see dark restorations in your teeth when you smile? Yes No
- Are there other smile concerns that you would like to discuss? Yes No