

YOUR DENTAL AND MEDICAL HISTORY ARE IMPORTANT. MANY THINGS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH. THE INFORMATION YOU PROVIDE IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT PERMISSION.

Medical Health

1. **General Health** Excellent Good Fair Poor

Patients name (PRINT) _____ Date _____

Name and Address of physician _____

Date of Last Complete physical _____

Are you taking any prescription/over-the-counter drugs? _____

If Yes, Please List Each One: _____

2. **Do you have, or have you ever been treated for:**

- | | | | | | |
|-----------------------------------|------------------------------|-----------------------------|--------------------------------------|------------------------------|-----------------------------|
| High/ Low Blood Pressure..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Sinus Trouble..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Heart Attack..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Asthma..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Heart Surgery..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Surgical Shunts, Plates or Pins..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Heart Murmur..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Artificial Joints | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Stroke..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Kidney Disease..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Artificial Heart Valve..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Thyroid Disease..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Heart Pacemaker..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Arthritis..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Congestive Heart Disease..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Eating disorders..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Mental Illness..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Hepatitis/ Liver Disease..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Anemia..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Drug or Alcohol Addiction..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Rheumatic Fever..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Glaucoma..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Diabetes..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Cancer..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Epilepsy..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Hemophilia..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Tuberculosis or Lung Disease..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | HIV Positive /AIDS..... | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Ulcers / Colitis..... | yes <input type="checkbox"/> | no <input type="checkbox"/> | Acid Reflux | yes <input type="checkbox"/> | no <input type="checkbox"/> |

Are you currently taking or have you ever taken bisphosphonates, either orally or by I.V.? yes no

(examples: Aredia, Zometa, Fosamax, Actonel, Boniva)

Have you ever been treated with radiation therapy or chemotherapy.....yes no

Are you allergic to any of the following drugs? Penicillin Aspirin Erythromycin Nitrous Oxide
 Dental Anesthetics Codeine Tetracycline Latex

Please list any other drugs that you are allergic to: _____

Other physical conditions we should be aware of: _____

Are you subject to prolonged bleeding?yes no

Are you taking blood thinners?yes no

Are you subject to fainting spells?yes no

Are you taking birth control pills?.....yes no

Are you pregnant.....yes no

Dental History

Your current dental health is: Excellent Good Fair Poor

Dates: last cleaning?_____ last cavity detection (bite wings) x-rays? _____ last exam?_____ last full mouth series x-rays ?_____

Do you use: cigarettes pipe chewing tobacco cigars gum alcoholic beverages coffee tea soft drinks

If you have diabetes , what is your normal blood sugar?_____how often do you check ? _____

How often do you floss your teeth? 1 time 2 times 3 times a day When? morning midday night

How often do you brush your teeth? 1 time 2 times 3 times a day When? morning midday night

Have you had orthodontic treatment (braces)?..... yes no If yes, when ? _____

Have you had previous periodontal care?..... .yes no If yes, when ? _____

Electric tooth brush?yes no What type ? _____

Have you experienced residual numbness or unusual sensation around lips or tongue?yes no

Have you had any head, neck ,or jaw injuries ?... ..yes no

Do you grind or clench your teeth?..... yes no

Do you have any noticeable wear on your teeth ? yes no

Have you had any complications with extractions? yes no

Are your teeth sensitive to heat cold sweet sour chewing?yes no Where ? _____

Do you have bleeding gums while brushing or flossing?yes no

Are you aware of any swelling, tenderness or lumps in your mouth?yes no

Do you get cold sores/fever blisters? yes no

Do you have chronic headaches? migraines? yes no

Do you hear popping clicking snapping noises when you chew?..... yes no

Can you chew on both sides of your mouth with-out pain?..... yes no If no, where is your pain ? __

Have you had any unpleasant dental experiences in the past?..... yes no _____

Are you having any dental problems that require immediate attention?.....yes no

Do you have family history of Heart Disease? Diabetes? Periodontal Disease?..... yes no Explain _____

Cosmetic Dental Makeover: Self-Test

- Are you self-conscious about your smile?yes no
- Do you feel your smile makes you look older?.....yes no
- Do you feel your smile looks "older" because your teeth are worn down?..... yes no
- Do spaces or gaps in your teeth make you self-conscious?yes no
- Are your teeth stained or too yellow?yes no
- Do you notice dark fillings or crowns when you smile? yes no
- Are your teeth crooked, chipped, or crowded?..... yes no
- Do you cover your mouth with your hand when you speak or smile?yes no
- Do you avoid smiling when you have your picture taken ? yes no

If you answered "Yes" to any of these questions, you may benefit from Dr. Fleming's Dental Cosmetic Transformation.

I hereby state that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent , any necessary dental services I may need during diagnosis and treatment.

Signature _____ Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.