

Patient: _____

Date of Birth: _____

What did you like about your past experiences at dental/doctors' offices? _____

What did you dislike? _____

Have you ever considered bleaching, bonding or braces for your teeth? ___ Yes ___ No

Would you like whiter teeth? ___ Yes ___ No

Are there any chips or stains on your teeth that concern you? ___ Yes ___ No

Although dental personal primarily treat in the area in and around your mouth, your mouth is 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 If yes, please explain _____

Are you on a special diet? ___ Yes ___ No If yes, please explain _____

Do you use tobacco? ___ Yes ___ No If yes, please explain _____

Do you use controlled substances? ___ Yes ___ No If yes, please explain _____

Women: are you pregnant or trying to get pregnant? ___ Yes ___ No If yes, please explain _____

Nursing? ___ Yes ___ No If yes, please explain _____

Taking oral contraceptives? ___ Yes ___ No If yes, please explain _____

Are you allergic to any of the following? (please circle) Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other: If yes, please list and explain: _____

Do you have or have you had any of the following? (If no, please mark each with "N" or line down the row. If yes, please circle and explain below):

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Problems Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Explain: _____

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

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

SIGNATURE of PATIENT, PARENT or GUARDIAN _____ DATE _____