Date: ____/____/_____

Patient Name: _____

Birthdate: ____/____/_____

ROGERS CENTER FOR DENTISTRY

MEDICAL INFORMATION

Do you consider yourself in good health? . . . . . Yes No
Are you currently being treated by a physician? . . . . . Yes No

If yes, please specify: _____

Physician's Name: _____

Physician's Phone Number: _____

Do you have or have you had any of the following conditions?

Cardiovascular disease . . . . . Yes No
Angina . . . . . Yes No
Damaged heart valve . . . . . Yes No
Congestive heart failure . . . . . Yes No
Previous infective endocarditis . . . . . Yes No
Artificial heart valve . . . . . Yes No
Damaged valves in transplanted heart . . . . . Yes No
Congenital heart disease (CHD)
Unrepaired, cyanotic CHD . . . . . Yes No
Repaired (completely) in last 6 months . . . . Yes No
Repaired CHD with residual defects . . . . . Yes No
Heart attack . . . . . Yes No
Heart Murmur . . . . . Yes No
Heart surgery . . . . . Yes No
Artificial Heart valve . . . . . Yes No
Pacemaker . . . . . Yes No
Abnormal bleeding . . . . . Yes No
Hemophilia . . . . . Yes No
AIDS or HIV infection . . . . . Yes No
Bronchitis . . . . . Yes No
Sinus trouble . . . . . Yes No
Cancer/Chemotherapy/Radiation treatment . . . . . Yes No
Ulcers . . . . . Yes No
Gastrointestinal disease . . . . . Yes No
Thyroid problems . . . . . Yes No
Glaucoma . . . . . Yes No
Epilepsy . . . . . Yes No
Fainting spells or seizures . . . . . Yes No
Sleep disorder . . . . . Yes No
Mental health disorder . . . . . Yes No
Kidney problems . . . . . Yes No
Osteoporosis . . . . . Yes No
Artificial Joint . . . . . Yes No
Easy Bruising . . . . . Yes No
Stroke . . . . . Yes No
High Blood Pressure . . . . . Yes No
Hepatitis/Liver Disease . . . . . Yes No
Arthritis . . . . . Yes No
Asthma . . . . . Yes No
Diabetes . . . . . Yes No
Immune System Disorders . . . . . Yes No
Kidney Disease . . . . . Yes No
Rheumatic fever . . . . . Yes No
Tuberculosis . . . . . Yes No
Venereal Disease . . . . . Yes No
Smoking or smokeless tobacco . . . . . Yes No
Alcohol . . . . . Yes No
Recreational Drugs . . . . . Yes No
Oral Bisphosphonates for osteoporosis or Paget's disease (for example, Fosamax, Actonel, Boniva) . . . . . Yes No
IV Bisphosphonates for bone pain, hypercalcemia, multiple myeloma, or metastatic cancer (Aredia, Zometa) . . . . . Yes No
Joint Replacement . . . . . Yes No
Date(s) of surgery _____
Women: Are you pregnant or nursing? . . . . . Yes No
Other diseases or conditions not listed above that you think I should know about:

_____

Please List Surgeries: _____

_____

Has a physician recommended that you take antibiotics prior to dental treatment? . . . . . Yes No

Current Medications: _____

_____

Allergies: _____

DENTAL INFORMATION

Do your gums bleed when you brush or floss? . . . . . Yes No
Are your teeth sensitive to cold, hot, sweets, or pressure? . . . . . Yes No
Does food or floss catch between your teeth? . . . . . Yes No
Is your mouth dry? . . . . . Yes No
Have you had any previous periodontal (gum) treatment? . . . . . Yes No
Have you ever had orthodontic treatment? . . . . . Yes No
Have you had any problems associated with previous dental treatment? . . . . . Yes No
Do you have earaches or neck pains? . . . . . Yes No
Do you have any clicking, popping, or discomfort in the jaw? . . . . . Yes No
Do you brux or grind your teeth? . . . . . Yes No
Do you have sores or ulcers in your mouth? . . . . . Yes No
Have you ever had a serious injury to your head or mouth? . . . . . Yes No
When was your last dental exam: _____
What can we do to make your visit as comfortable as possible with us?_____
Would you change anything about your smile? . . . . . Yes No
Have you ever whitened your teeth? . . . . . Yes No
Would you like to learn more about teeth whitening? . Yes No