

# BRUSH SM COUNTRY

## DENTAL & SPECIALTY CENTER

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

Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security # \_\_\_\_\_ BirthDate: \_\_\_\_\_

Phone(Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Ext): \_\_\_\_\_ (Cellular): \_\_\_\_\_

Address: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

1.  YES  NO Has there been any changes in your health in the last year? If yes, please explain: \_\_\_\_\_
2.  YES  NO Have you ever been hospitalized, had a major operation or serious illness? Please explain: \_\_\_\_\_
3.  YES  NO Have you seen a doctor in the last year? Date of Visit: \_\_\_\_\_ Reason: \_\_\_\_\_
4.  YES  NO Are you currently receiving regular medical care or treatment by your doctor? If yes, for what conditions? \_\_\_\_\_
5.  YES  NO Are you allergic to or have you had any unusual reactions to any medications? If yes, what medications and what reactions? \_\_\_\_\_
6.  YES  NO Are you currently taking any medications (prescription and over-the-counter drugs)? If yes, what medications and for what conditions? \_\_\_\_\_
7.  YES  NO Have you ever, or are you currently, taking any of the following medicines: Fosamax, Aredia, Zometa, or any Biophosphonates? \_\_\_\_\_
8.  YES  NO Have you ever, or are you currently, using recreational drugs? If yes, which drug(s) and for how long? \_\_\_\_\_
9.  YES  NO Do you have any blood disorders such as hemophilia or anemia? If yes, please explain: \_\_\_\_\_
10.  YES  NO AIDS or HIV? If yes, please explain: \_\_\_\_\_
11.  YES  NO Cancer, radiation treatments, or chemotherapy? If yes, please explain: \_\_\_\_\_
12.  YES  NO Diabetes or blood sugar problems? If yes, please explain: \_\_\_\_\_
13.  YES  NO Tumors or growths? If yes, please explain: \_\_\_\_\_
14.  YES  NO Allergies to metal, such as earrings or jewelry? If yes, please explain: \_\_\_\_\_
15.  YES  NO Do you use tobacco products? What tobacco product(s)? \_\_\_\_\_ How long? \_\_\_\_\_
16.  YES  NO Damaged heart valves, including heart murmur and/or rheumatic heart disease? If yes, please explain: \_\_\_\_\_
17.  YES  NO Congenital heart problems? If yes, please explain: \_\_\_\_\_
18.  YES  NO Heart trouble, heart attack, high blood pressure, or stroke? If yes, please explain: \_\_\_\_\_
19.  YES  NO Do you have pain in your chest upon exertion? Explain: \_\_\_\_\_
20.  YES  NO Are you short of breath after mild exercise? If yes, please explain: \_\_\_\_\_
21.  YES  NO Do your ankles swell? If yes, please explain: \_\_\_\_\_
22.  YES  NO Do you have breathing problems, emphysema, tuberculosis, or other lung problems? If yes, please explain: \_\_\_\_\_
23.  YES  NO Asthma, hay fever, or hives? Please explain: \_\_\_\_\_
24.  YES  NO Stomach, intestinal disease, or ulcers? Please explain: \_\_\_\_\_
25.  YES  NO Hepatitis, jaundice, or liver disease? Please explain: \_\_\_\_\_
26.  YES  NO Seizures, fainting spells, numbness, or other neurological problems? If yes, please explain: \_\_\_\_\_
27.  YES  NO Phobias, severe anxieties, depression, psychoses or other mental problems? If yes, please explain: \_\_\_\_\_
28.  YES  NO Joint replacement or artificial joints? Please explain: \_\_\_\_\_
29.  YES  NO Women only: Are you pregnant? Due date: \_\_\_\_\_
30.  YES  NO Do you have any major dental concerns? Please explain: \_\_\_\_\_
31.  YES  NO Have you ever fainted during a dental visit? Please explain: \_\_\_\_\_
32.  YES  NO Have you experienced an unusual reaction to a dental anesthetic or dental medication? Please explain: \_\_\_\_\_
33.  YES  NO Have you experienced prolonged bleeding following dental treatment? Explain: \_\_\_\_\_
34.  YES  NO Have you had any other complications following dental treatment? Explain: \_\_\_\_\_
35.  YES  NO Have you ever had any injury to your teeth, face, or jaw? Explain: \_\_\_\_\_
36.  YES  NO Do you have any pain, popping, or clicks in your jaw joint (TMJ)? Explain: \_\_\_\_\_
37.  YES  NO Would you change anything about the appearance of your teeth? What? \_\_\_\_\_