THE DENTISTRY AND IMPLANTOLOGY GROUP OF ORLAND PARK

Patient's Name______________________________

1. When was your last dental check-up?______________________________
2. How often do you brush your teeth?__________ Is your brush hard, soft, or medium? ________
3. Do you floss your teeth? YES NO How often?______________________________
4. Are your teeth sensitive to hot or cold? . . . . YES NO
5. Do your gums bleed? . . . . YES NO
6. Are you having any pain or discomfort at this time? . . . . YES NO
7. Have dental procedures ever been recommended to you that you didn't have done? . . . . YES NO
8. Have you ever had a bad experience in the dental office? . . . . YES NO
9. Are you nervous about the care you are about to receive? . . . . YES NO
10. Do you frequently get blisters on your lips or in your mouth? . . . . YES NO
11. Are you unhappy in any way with the appearance of your teeth? . . . . YES NO
12. Do you feel your teeth are affecting your health or your eating habits? . . . . YES NO
13. Are you interested in:
    ❑ Professional Whitening ❑ Braces/Invisalign ❑ Implants

Do you smoke? ____________________How many packs a day? ____________________

Do you chew tobacco?____________________ How often?____________________

MEDICAL HISTORY

1. Are you in good health? . . . . YES NO
2. Has there been any change in your general health within the past year? . . . . YES NO
3. When was your last physical examination?______________________________
4. Are you now under the care of a physician? . . . . YES NO
   What is the condition being treated? ______________________________
5. My physician is:
   Name______________________________ Phone ______________
   Address____________________City, State, Zip____________________
6. Have you ever been hospitalized or had a serious illness or operation? . . . . YES NO
   If so, what was the problem?______________________________
7. Do you have or have you had any of the following diseases or problems? . . . . YES NO
   A. Damaged heart valves or artificial heart valves including mitral valve prolapse? . . . . YES NO
   B. Congenital heart lesions? . . . . YES NO
   C. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, rheumatic heart disease) . . . . YES NO
      1) Do you have pain in the chest upon exercise? . . . . YES NO
      2) Do your ankles swell? . . . . YES NO
      3) Do you get short of breath with mild exertion or do you require extra pillows when you sleep? . . . YES NO
      4) Do you have a cardiac pacemaker? . . . . YES NO
   D. Artificial Joints? . . . . YES NO
   E. Sinus trouble or allergies? . . . . YES NO
   F. Hives or skin rash? . . . . YES NO
   G. Fainting spells or seizures? . . . . YES NO

(over)

H. Diabetes? .... YES NO

1) Do you have to urinate more than 6 times a day? .... YES NO

2) Are you thirsty much of the time? .... YES NO

3) Does your mouth often become dry? .... YES NO

I. Hepatitis? .... YES NO

J. Arthritis or inflammatory rheumatism (painful swollen joints)? .... YES NO

K. Stomach ulcers? .... YES NO

L. Kidney troubles? .... YES NO

M. Tuberculosis? .... YES NO

N. Do you have a persistent cough or cough up blood? .... YES NO

O. Low blood pressure? .... YES NO

P. Venereal disease? .... YES NO

Q. AIDS or test positive for HIV antibodies? .... YES NO

8. Have you ever been exposed to hepatitis or AIDS? .... YES NO

9. Have you had abnormal bleeding associated with previous extraction, surgery or trauma? ...... YES NO

A. Do you bruise easily? .... YES NO

B. Have you ever required a blood transfusion? .... YES NO

If so, explain the circumstances______________________________

10. Do you have any blood disorder such as anemia? .... YES NO

11. Have you had surgery or x-rays for a tumor, growth, or other condition of your head or neck? . YES NO

12. Name and dose of medicines you are taking including over-the-counter drugs or herbal supplements

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13. ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO:

A. Latex .... YES NO

B. Penicillin or other antibiotics? .... YES NO

C. Barbiturates, sedatives or sleeping pills? .... YES NO

D. Aspirin? .... YES NO

E. Iodine? .... YES NO

F. Codeine or other narcotics? .... YES NO

G. Other?______________________________

14. Do you have any disease, condition or problem not listed? .... YES NO

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15. Are you employed in any situation which exposes you regularly to x-ray or other ionizing radiation? YES NO

16. Are you wearing contact lenses? .... YES NO

WOMEN

17. Are you pregnant? .... YES NO

18. Do you have any problems associated with your menstrual period? .... YES NO

19. Are you nursing? .... YES NO

SIGNATURE OF PATIENT______________________ DATE__________________

If you are filling out this form for someone other than yourself, please sign here and indicate your relationship to the patient.

SIGNATURE______________________ RELATIONSHIP __________________