

**Other Information**

**WHO IS YOUR MEDICAL DOCTOR?** \_\_\_\_\_

**DATE OF LAST DOCTOR VISIT AND REASON?** \_\_\_\_\_

**WHAT PHARMACY DO YOU USE?** \_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR OFFICE?** \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU EVER HAD?** *Circle and explain any yes answers.*

Heart condition, murmur, bypass or mitral valve prolapse? \_\_\_\_\_

Heart attack or stroke? \_\_\_\_\_

Chest pain upon exertion? \_\_\_\_\_

Pacemaker? \_\_\_\_\_

Blood disorder or abnormal bleeding? \_\_\_\_\_

Dizziness, fainting, shortness of breath? \_\_\_\_\_

Cancer, tumor or cyst? \_\_\_\_\_

Hepatitis, Jaundice or liver disorder? \_\_\_\_\_

Stomach, digestive or intestinal disorders? \_\_\_\_\_

Diabetes or family history of diabetes? \_\_\_\_\_

Emotional, psychological, mental disorders? \_\_\_\_\_

Sexually transmitted disease? \_\_\_\_\_

Hospitalization within past 5 years? If so, why? \_\_\_\_\_

Are you now under a doctor's care? Why? \_\_\_\_\_

High or low blood pressure? \_\_\_\_\_

Rheumatic fever, systemic lupus? \_\_\_\_\_

Asthma, Emphysema, Bronchitis, TB? \_\_\_\_\_

Radiation or Chemotherapy? When? \_\_\_\_\_

Kidney, bladder or urinary tract disorder? \_\_\_\_\_

Joint or organ surgery or transplant? (explain) \_\_\_\_\_

Neurological (nerve) disorder, seizures? \_\_\_\_\_

Thyroid condition, hormone imbalance? \_\_\_\_\_

HIV+, AIDS, AIDS exposure or drug use? \_\_\_\_\_

Allergies (drugs, food, environmental)? \_\_\_\_\_

Smoked or used smokeless tobacco? \_\_\_\_\_

Drink more than one soda pop a day? \_\_\_\_\_

Suck on hard candy throughout the day? \_\_\_\_\_

Ever notice your mouth feeling dry? \_\_\_\_\_

Acid reflux or use antacids on a regular basis? \_\_\_\_\_

Brush your teeth daily? \_\_\_\_\_

Floss daily? \_\_\_\_\_

Been told you have periodontal disease? \_\_\_\_\_

FEMALES: Are you pregnant? \_\_\_\_\_

Explain any other information concerning your health \_\_\_\_\_

Please list any medications you are currently taking (including OTC) \_\_\_\_\_

Please list any additional medications (including OTC and diet) taken within the last year. \_\_\_\_\_

What is your main concern today? \_\_\_\_\_

Is there anything you would like to change about your smile? \_\_\_\_\_

Have you ever thought about whitening your teeth? \_\_\_\_\_

INITIAL/DATE \_\_\_\_\_