

-----**Appointment Information**-----

What is the purpose of your visit with us today?

Are you having any dental problems you would like Dr. Spina to address?

Have you had any of the following treatments: (please circle)

Silver Fillings Crowns Bridges Root Canal Dental Implants Veneers

If you have silver (amalgam) fillings, do you want to discuss replacing them with more natural looking restorations?

Have you ever been treated for TMJ / Jaw Pain / tooth grinding? **Yes / No**

Do you wear a nightguard? **Yes/No**

How do you feel about your smile? Do you wish to discuss any cosmetic concerns with Dr. Spina?

Is there anything else you want to discuss at your visit today?

-----**Medical History**-----

Please List the **ALL MEDICATIONS** you are currently taking:

Please List **ALL MEDICATIONS and FOODS** you are allergic to:

Do you have an artificial or prosthetic Joint? **Yes/No**

When was it placed?

Has your prosthetic ever been infected?

For the following questions, circle Yes or No. Your answers are for our records only and will be kept confidential.

- | | |
|--|--|
| 1. Are you in good health.....Yes No | 29. TB, Tuberculosis (Self, Family, Household)Yes No |
| 2. Has there been any change in your general health within the past year? Yes No | 30. Persistent cough/ cough that produces blood ... Yes No |
| Have you ever had or do you now have? | 31. Arthritis or painful/swollen joints Yes No |
| 3. Pacemaker Yes No | 32. Artificial joint replacement Yes No |
| 4. Heart Murmur Yes No | 33. Stomach ulcer or hyperacidity Yes No |
| 5. Mitral valve prolapse Yes No | 34. Kidney trouble or dialysis Yes No |
| 6. Rheumatic heart disease Yes No | 35. Persistent swollen glands in neckYes No |
| 7. Damaged heart valve Yes No | 36. Sexually transmitted diseaseYes No |
| 8. Heart trouble Yes No | 37. Epilepsy / neurological diseaseYes No |
| 9. Heart attack Yes No | 38. PsychotherapyYes No |
| 10. Angina Yes No | 39. Problems with mental healthYes No |
| 11. High Blood Pressure Yes No | 40. CancerYes No |
| 12. Arteriosclerosis)Yes No | 41. Problems of the immune system Yes No |
| 13. Stroke Yes No | 42. Rheumatic fever or scarlet fever Yes No |
| 14. Chest pain upon exertion Yes No | 43. Abnormal bleedingYes No |
| 15.Shortness of breath after mild exercise or when lying down? Yes No | 44. Blood transfusionYes No |
| 16. Swollen ankles Yes No | 45. Blood disorders such as anemia..... Yes No |
| 17. Congenital heart defect Yes No | 46. Tumor or growthYes No |
| 18. Prosthetic (artificial) heart valve Yes No | 47. Allergic or other reaction to |
| 19. Allergy Yes No | a. local anesthetics..... Yes/No |
| 20. Sinus trouble Yes No | b. Penicillin or other antibiotics Yes No |
| | c. Sulfa drugs Yes No |
| | d. Latex..... Yes No |

- 21. Asthma or hay fever Yes No
- 22. Fainting spells or seizures Yes No
- 23. Persistent diarrhea or recent weight loss Yes No
- 24. Diabetes Yes No
- 25. Hepatitis, jaundice or liver disease Yes No
- 26. AIDS or HIV infection Yes No
- 27. Thyroid problems Yes No
- 28. Respiratory problems, emphysema,
bronchitis, etc. Yes No

e. Aspirin Yes No

f. Codeine Yes No

g. Other Yes No

Women

48. Are you pregnant?..... Yes No

49. Do you have any problems associated with your
menstrual period? Yes No

50. Are you nursing?. Yes No

Please explain YES answers above and list serious illnesses, operations and hospitalizations within past five years:

Are you now under the care of a doctor? Yes No If Yes, what is the condition being treated?

I certify that I have read and understood the above. I acknowledge that any questions I had about the inquiries above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any errors that I may have made in the completion of this form.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN Date