PROFOUND
ORTHODONTICS

NAME_____

BIRTHDATE_____

Reason for visit _____

When was your last dental visit? _____

Primary Dentist:_____

1. How often do you brush?_____ Floss?_____
2. Do your gums bleed? YES NO
3. Are your teeth sensitive? YES NO
4. Do you have any areas of frequent food impaction? YES NO
5. Any of the following jaw problems?
   ___Clicking ___Pain ___ Opening ___Closing ___Chewing
6. Any head, neck, or jaw injuries? YES NO
7. Do you have frequent headaches? YES NO
8. Do you clench or grind you teeth? YES NO
9. Do you like the appearance of your teeth? YES NO

PRIMARY CARE PHYSICIAN_____ DATE OF LAST EXAM_____

1. If you are under medical treatment now? Please explain below:
   _____
2. Are you taking any bisphosphonates (Fosamax, Boniva)
   YES NO
3. Are you taking any medications including no-prescription medicine? List any below: YES NO
   _____
   _____
   _____
   _____
4. Do you have any allergies to:
   Penicillin YES NO
   Sulfa Drugs YES NO
   Codeine YES NO
   Latex YES NO
   Metals (cosmetic jewelry, nickel, etc) YES NO
   Other allergies: (Please list ANY others below)
   _____
   _____
   _____
5. WOMEN ONLY:
   Are you taking birth control pills? YES NO
   Are you nursing? YES NO
   Do you think you may be pregnant? YES NO
   Estimated date of delivery: _____

Please select if you have or have had any of the following:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism Spectrum
- ☐ Blood Transfusion
- ☐ Bruise or Bleed easily
- ☐ Cancer or Tumors
- ☐ Cold Sores (Herpes)
- ☐ Congenital Heart Lesion
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ G-6PD deficiency
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Disease or Angina
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis-Type: ___
- ☐ High Blood Pressure
- ☐ HIV+
- ☐ Hives
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Leukemia
- ☐ Mental Health Disorder
- ☐ Mitral Valve Prolapse
- ☐ Nervousness
- ☐ Pacemaker
- ☐ Painful Joints
- ☐ Persistent Cough
- ☐ Prosthetic Heart Valves
- ☐ Prosthetic Joints
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Diseases
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Steroid Medications
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis or PPD+
- ☐ Ulcers or Gastric Reflux
- ☐ Yellow Jaundice

Patient/Guardian Signature:_____ **Date:**_____ **Dr. Justin Kammo:**_____ **Date:**