PATIENT HEALTH RECORD

Date _____

Name _____ Spouse's Name _____
Address _____
(street) (city) (zip)
Home Phone _____ Cell Phone _____Work phone _____
Date of Birth_____Male _____ Female _____ Height _____Weight_____
Occupation _____SSN _____ Single _____ Married _____
Closest Relative _____ Phone _____
Whom may we thank for referring you to us? _____

MEDICAL HEALTH
Name and address of physician _____
Have you been under a physician's care during the past 2 years? _____ For _____
Have you been treated in a hospital in the last 2 years? _____ For _____
Have you ever had major surgery? _____
If female: Are you taking hormones or birth control? _____ Are you pregnant or nursing? _____
Have you ever had a blood test for hepatitis? _____Were you vaccinated? _____
Have you ever had cankers or cold sores on your lips, tongue, gums, or body? _____
Are you now taking or have you taken any prescription drugs during the past year? _____ For _____
_____

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Other_____
Have you had or do you now have any of the following:

	YES	NO
Abnormal blood pressure	( )	( )
Allergies	( )	( )
AIDS	( )	( )
Anemia	( )	( )
Angina	( )	( )
Arthritis	( )	( )
Artificial heart valves	( )	( )
Artificial joints	( )	( )
Asthma	( )	( )
Cancer	( )	( )
Chemotherapy	( )	( )
Congenital heart lesions	( )	( )
Diabetes	( )	( )
Drug dependency	( )	( )
Epilepsy	( )	( )
Fainting	( )	( )
Glaucoma	( )	( )
Heart disease	( )	( )
Heart murmur	( )	( )
HIV	( )	( )

	YES	NO
Hepatitis	( )	( )
Herpes	( )	( )
Jaundice	( )	( )
Kidney disease	( )	( )
Liver disease	( )	( )
Organ transplant	( )	( )
Pacemaker	( )	( )
Polio	( )	( )
Prolonged bleeding	( )	( )
Prolonged cough	( )	( )
Psychiatric treatment	( )	( )
Radiation therapy	( )	( )
Rheumatic fever	( )	( )
Sickle cell anemia	( )	( )
Stroke	( )	( )
Thyroid disease	( )	( )
Tuberculosis	( )	( )
Ulcers	( )	( )
Venereal Disease	( )	( )

Have you had any disease, condition, or problem not previously listed? _____
_____
_____

DENTAL HEALTH

When was your last dental visit? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot_____ Cold_____ Sweets _____ Chewing _____

How often do you brush your teeth? _____Floss? _____ Water Jet_____

Do your gums bleed while cleaning? _____

Have you ever had periodontal treatment? _____ When? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____Click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____

Do you have frequent headaches? _____ Ear aches? _____

Have you ever had orthodontic treatment (braces)? _____ When _____

Do you lose fillings or break fillings? _____

Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken teeth _____

Do you have any noticeable wear on your teeth? _____Food traps _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? Fixed bridge _____ Removable partial_____ Full denture_____ Dental Implant_____

Are you comfortable with the replacement? _____Please describe_____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your appearance? _____

If yes, are you pleased with the result? Please comment: _____

_____

Have you ever had an unpleasant dental experience? _____

Please add anything you feel is important _____

Signature: _____ Date _____