PATIENT HEALTH RECORD

Date______________

Name____________________________________ Spouse's Name__________________________________
Address____ City, State, Zip___________________
Business Address____ City, State, Zip___________________
Home Phone:__________________ Business Phone:_________________ Cell# _________________________
E-Mail: ____
Date of Birth______________________Sex_________Height____________Weight__________________
Social Security No.:_______-_____-______Single_________ Married________
Closest Relative for Emergency Contact_______________________________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 past 2 years?____For?______________________________________
Have you ever had major surgery?___For?____
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?____When?______Re-test?______
Have you had cankers or cold sores on your lips, tongue, gums or body?___________________Treated?______
Are you now taking or have you taken any prescription drugs during the past year?_______________________
*For?____
Are you allergic to : ___Penicillin/Amoxicillin___Codeine___Latex___Local Anesthetics___Aspirin
Other:____

Have you had or do you now have:

	yes	no		yes	no		yes	no
Abnormal blood pressure…….…...	__	__	Hepatitis: A, B, C, D	__	__	Respiratory Problem	__	__
AIDS or ARC................. ....…	__	__	Herpes Type:_________........	__	__	Emphysema………..	__	__
Allergies......................................	__	__	Jaundice.......................…....	__	__	Bleeding Problems...	__	__
Anemia......................................	__	__	Kidney Disease.....…............	__	__	Back Problems…….	__	__
Angina....................................... .	__	__	Liver Disease.............….…...	__	__	Hypertension………	__	__
Arthritis........Type___________....	__	__	Organ Transplant_________..	__	__	Hypotension………	__	__
Artificial joints.............................	__	__	Polio....................................	__	__	Sinus Problems…...	__	__
Asthma.....................................…	__	__	Prolonged bleeding...............	__	__	Tobacco Use………	__	__
Cancer/Tumors...........................	__	__	Prolonged cough..................	__	__	If Yes-**Type**:__________		
Chemotherapy............................	__	__	Psychiatric treatment..........	__	__	**Amount:**____________		
Congenital heart lesions................	__	__	Radiation therapy............…. .	__	__	**How Long:**__________		
Diabetes/Hypoglycemia.......... ….	__	__	Rheumatic fever…….…...… .	__	__			
Drug dependency........................	__	__	Sickle cell anemia.........…....	__	__			
Epilepsy/Seizures.......................	__	__	Stroke (CVA) ....…....... ..	__	__			
Fainting.....................................	__	__	Thyroid Disease:Hyper/Hypo.	__	__			
Glaucoma……….…...................	__	__	Tuberculosis (TB)...	__	__			
Heart disease or Pacemaker......….	__	__	Ulcers................................. .	__	__			
Heart murmur or MVP............... .	__	__	Venereal Disease:_________ .	__	__			
HIV...… .	__	__	Shingles…………………….	__	__			

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

DENTAL HEALTH

When was your last dental visit?____
How often did you regularly see your dentist?_____________________________________
Are you having any dental problems that require immediate attention?__________________
Do any of the following cause tooth discomfort? Hot____ Cold____ Sweets____ Chewing____Other?_______
How often do you brush your teeth?___________Floss?______________Water Jet?_________Other?_______
Do your gums bleed while cleaning?__________Regularly?___________Occasionally?___________________
Do your gums ever feel tender or swollen?_____Regularly?___________Occasionally?___________________
Have you had periodontal treatment?__________When?_______________Surgery?___ Type:______________
Do you clench or grind your teeth?___________Regularly?___________Occasionally?________Treated?____
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?__________________________________Earaches?_____________________
Have you ever had orthodontic treatment (braces)?__________When?___________Treatment Time:_________
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 and 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 aesthetic 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:______________________