PATIENT HEALTH RECORD

Date _____

Dr. Mr. Mrs. Ms. _____ Spouses Name _____
(Last) (first) (initial)

Address _____
(Street) (city) (state) (zip code)

Home Phone (___)_____ Business Phone (___)_____ E-Mail _____

Date of Birth _____ Sex M F Height _____Weight _____ Married _____ Single _____

Occupation _____ Social Security No. _____ - _____ - _____

Emergency Contact - Name _____ Phone Number (_____) _____

Whom may we thank for referring you to us? _____

MEDICAL HEALTH

What is your general state of health? Excellent _____ Good _____ Fair _____ Poor _____

Name and address and phone number of physician _____

_____

Have you been under a physician's care during the last two years? _____

Have you been treated in a hospital in the past three years? _____

Have you had major surgery? _____

History with general or IV anesthesia? _____

If female: Are you pregnant or nursing? _____

Do you or have you had any of the following?

Blood Pressure (office to take) _____

	Past	Present	None		Past	Present	None		Past	Present	None
Epilepsy or Seizures	☐	☐	☐	Kidney Problems	☐	☐	☐	Cancer	☐	☐	☐
Fainting or Dizziness	☐	☐	☐	Bruise/Bleeds easily	☐	☐	☐	Chemotherapy	☐	☐	☐
Stroke	☐	☐	☐	Heart Problem	☐	☐	☐	Radiation Therapy	☐	☐	☐
Persistent Cough	☐	☐	☐	Chest Pain/Angina	☐	☐	☐	Thyroid Disease	☐	☐	☐
Emphysema/Bronchitis	☐	☐	☐	High Blood Pressure	☐	☐	☐	AIDS/HIV+	☐	☐	☐
Tuberculosis/PPD+	☐	☐	☐	Rheumatic Fever	☐	☐	☐	Arthritis	☐	☐	☐
Asthma	☐	☐	☐	Heart Murmur	☐	☐	☐	Artificial Joints	☐	☐	☐
Sinus Problems	☐	☐	☐	Mitral Valve Prolapse	☐	☐	☐	Diabetes	☐	☐	☐
Anemia/Sickle Cell	☐	☐	☐	Congenital Heart Lesions	☐	☐	☐	Organ Transplants	☐	☐	☐
Hepatitis A, B, C	☐	☐	☐	Heart Surgery	☐	☐	☐	Osteoporosis/penia	☐	☐	☐
Liver Disease	☐	☐	☐	Artificial Heart Valves	☐	☐	☐	Snoring	☐	☐	☐
Pneumonia	☐	☐	☐	Pacemaker	☐	☐	☐	Sleep Apnea	☐	☐	☐
Nervousness/Anxious	☐	☐	☐	Fibromyalgia	☐	☐	☐	Dry Mouth	☐	☐	☐
Irregular Heart Beat	☐	☐	☐	Latex Allergy	☐	☐	☐	Tobacco Use	☐	☐	☐

Do you have any condition, disease, or problem not previously listed? _____

_____

_____

Please list all the medication you are taking, including over the counter drugs and herbs:

Medication:	Dosage:	Times/day	Medication:	Dosage:	Times/day

Are you allergic to:

❑ Penicillin ❑ Codeine ❑ Local Anesthetics

Any allergies not listed above: _____

DENTAL HEALTH

When was your last dental visit? _____ How often did you see your dentist? _____
Are you having any dental problems that require immediate attention? _____
Do you have frequent headaches? _____ Ear aches? _____ How often? _____
Is there anything that will cause your muscles to be tired or sore or cause headaches? _____
Are your jaw joints painful or tender? _____ If yes, please describe: _____
Have you had trauma to your jaw? _____ Does your jaw joints pop or click or grate? _____
Do your jaws ever feel tired or ache? _____ Have you ever been told you have TMJ? _____
Do you clench or grind your teeth? _____
Does your bite feel comfortable?_____ Have you noticed any change in your bite? _____
Do your gums bleed while cleaning? _____ Do your gums ever feel tender or swollen? _____
Have you ever been told you have periodontal disease and/or treatment? _____
How often do you brush your teeth? _____ Floss? _____ Water jet? _____
Do any of the following cause tooth discomfort? Hot _____ Cold ____ Sweets _____ Chewing _____
Have you noticed any changes in your teeth? _____
Do you have loose teeth? _____ Worn teeth? _____ Broken or chipped teeth? _____ Food Traps? _____
Can you chew on both sides of your mouth? _____ Comfortably? _____
Do you lose fillings or break fillings? _____ Do you usually have cavities? _____
Have you ever had orthodontic treatment? _____ When? _____
Do you have any missing teeth? _____ Have they been replaced? _____
Do you have a Fixed bridge? _____ Removable partial? _____ Full dentures? _____ Dental Implants? _____
Are you comfortable with the replacement? _____ Please describe: _____
_____
How do you feel about the appearance of your smile? _____
What improvements would you like to make in your mouth? _____
_____
Please add anything you feel is important: _____
_____
_____

Signature _____ Date _____

_____ _____

(Signature of Dentist) (Date)