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 medications you are taking, including over the Counter Drugs and Herbs

Medications:	Dosage:	Times/day	Medications	Dosage	Times/day

Are you allergic to: ❑ Penicillin, ❑ Codeine, ❑ Local Anesthetics, ❑Other _____

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? _____ Do 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? _____
Have you ever been told you have periodontal disease? _____ Have you ever had periodontal treatment? _____
Do your gums bleed while cleaning? _____ Do your gums ever feel tender or swollen? _____
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 _____