

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) _____

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

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 loose 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 _____