Patient Health Record

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DATE

NAME (Last) (First) (Middle)

HOME ADDRESS

BUSINESS ADDRESS

OCCUPATION

PHONE (Home) (Business)

(Cell) (Email)

DATE OF BIRTH SEX HEIGHT WEIGHT

MARITAL STATUS (circle) SINGLE MARRIED WIDOWED DIVORCED

SPOUSE'S NAME

SOCIAL SECURITY NUMBER

REFERRED BY

Reason for your visit

Emergency information - Name. Address and Telephone No. of an individual we can call.

MEDICAL HEALTH

General health (please check): Excellent ☐ Good ☐ Fair ☐ Poor ☐

Name and address of your physician _____

_____

Last Complete Physical? _____

Are you presently under the care of a physician? ..... Yes ☐ No ☐

If so, for what reason? _____

_____

Please list all the medications and vitamins you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you allergic to: Antibiotics ☐ Codeine ☐ Aspirin ☐ Local Anesthetics ☐

Or any Medications? _____

Have you ever been hospitalized? If so give name of hospital. reason and dates.

_____

_____

Have you had any radiological diagnostic x-ray in the last five years? ..... ☐ Yes ☐ No

Have you had any blood transfusions? ..... ☐ Yes ☐ No

Do you smoke cigarettes? Yes ☐ No ☐ How many per day? _____

Do you consume alcohol on a daily basis? ..... ☐ Yes ☐ No

Is your blood pressure Normal ☐ Low ☐ High ☐

Women: Are you pregnant? Yes ☐ No ☐ How long? _____

Do you have or have you ever been informed that you had any of the following:

Chest Pains ..... Yes ☐ No ☐

Heart Disease ..... Yes ☐ No ☐

Rheumatic Fever ..... Yes ☐ No ☐

Congenital Heart Defects ..... Yes ☐ No ☐

Heart Murmur ..... Yes ☐ No ☐

Postural Hypotension ..... Yes ☐ No ☐
(faint spells)

Hypertension ..... Yes ☐ No ☐

Kidney Problems ..... Yes ☐ No ☐

Stroke ..... Yes ☐ No ☐

Thyroid Problems ..... Yes ☐ No ☐

Hormonal Problems ..... Yes ☐ No ☐

Ulcers ..... Yes ☐ No ☐

Tuberculosis or Lung Disease Yes ☐ No ☐

Diabetes ..... Yes ☐ No ☐

Epilepsy or Seizures ..... Yes ☐ No ☐

Anemia ..... Yes ☐ No ☐

Cancer or Leukemia ..... Yes ☐ No ☐

Psychiatric Problems ..... Yes ☐ No ☐

Sickle Cell Disease ..... Yes ☐ No ☐

Enlarged Lymph Nodes .... Yes ☐ No ☐

Night Sweats..... Yes ☐ No ☐

Persistent Diarrhea ..... Yes ☐ No ☐

Blush-Reddish Lesions ..... Yes ☐ No ☐

Glaucoma ..... Yes ☐ No ☐

Prosthetic Valve or Joints ..... Yes ☐ No ☐

Bruise Easily ..... Yes ☐ No ☐

Jaundice ..... Yes ☐ No ☐

Asthma or Hay Fever ..... Yes ☐ No ☐

Allergies or Hives ..... Yes ☐ No ☐
Sinus Trouble

Arthritis ..... Yes ☐ No ☐

Excessive Urination ..... Yes ☐ No ☐
and/or Thirst

Persistent Cough ..... Yes ☐ No ☐

Prolonged Bleeding Problems Yes ☐ No ☐

Sexually Transmitted Diseases Yes ☐ No ☐
(Gonorrhea. Syphilis.
Genital Herpes)

Genetic Problems ..... Yes ☐ No ☐

Skin Disease ..... Yes ☐ No ☐

AIDS/HIV..... Yes ☐ No ☐

Unexplained Fevers ..... Yes ☐ No ☐

Prolonged Sore Throat ..... Yes ☐ No ☐

Fatigue..... Yes ☐ No ☐

Hepatitis..... Yes ☐ No ☐

Cold Sores, fever blisters Yes ☐ No ☐
or canker sores

DENTAL HEALTH

When was your last dental visit?_____

Have you ever had any serious problems associated with previous dental treatment?

Yes☐ No☐ If yes, explain: _____

What type of tooth brush do you use? Soft☐ Medium☐ Hard☐

Do you floss? _____

Do you routinely use a mouth rinse? Yes☐ No☐ How often?

Do you experience dry mouth (Xerostomia)? ..... Yes☐ No☐

Do your gums feel tender or swollen? ..... Yes☐ No☐

Do your gums bleed while brushing and/or flossing? ..... Yes☐ No☐

Do you experience pain with hot, cold, sweet, air or chewing? ..... Yes☐ No☐

Do you clench or grind your teeth while sleeping or during the day? ..... Yes☐ No☐

Do your facial muscles ever feel tired? ..... Yes☐ No☐

Do you wear full or partial dentures? Upper☐ Lower☐ ..... Yes☐ No☐

Do you have retention problems with your full or partial dentures? ..... Yes☐ No☐

Do you gag easily? ..... Yes☐ No☐

Are you apprehensive (nervous) about your dental treatment? ..... Yes☐ No☐

Please add anything you feel is important:

_____

_____

_____

Are you interested in whitening your teeth? ..... Yes☐ No☐

CONSENT

I authorize the Doctor to perform the diagnostic procedures deemed appropriate and necessary to make a thorough diagnosis of the patients' dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents. It is understood that payment is required as services are rendered and can be made by cash, check or credit card. Insurance is not accepted as payment. A fee will be charged for cancelled appointments without 48 hours notice.

_____

PATIENT SIGNATURE (PARENT OF CHILD) DATE