Patient Health Record

Patient Name:_____ Prefers to be called:_____ Date: _____

Physician Name: _____ Physician Location: _____

Phone: ( ) _____ Date of last Physical: _____

Have you received all standard required vaccines? Y / N

Have you ever been instructed to take antibiotics prior to any dental or surgical procedures? Y / N

Are you currently **taking any drugs, medications or herbal supplements**? Y / N

Please list the medication or herbal supplement and purpose: _____

_____

_____

Are you **allergic** to any drugs, medications or latex rubber? Please list: _____

_____

*Due to possible complications with anesthetic, I promise to disclose any and all changes or additions to medications and/or supplementation at my next schedules office visit. Initial _____

Do you now have, or have you ever had, any of the following? Please check the appropriate boxes.

Y N	Description	Date	Y N	Description	Date
❑ ❑	Heart Disease/Surgery	_____	❑ ❑	HIV Positive, ARC, or AIDS	_____
❑ ❑	Heart Murmur	_____	❑ ❑	Hepatitis (circle) A, B or C	_____
❑ ❑	Mitral Valve Prolapse	_____	❑ ❑	Diabetes	_____
❑ ❑	Heart Attack/Failure	_____	❑ ❑	Tuberculosis	_____
❑ ❑	Artificial Joint/Heart Failure	_____	❑ ❑	Emphysema	_____
❑ ❑	Abnormal Blood Pressure	_____	❑ ❑	Asthma	_____
❑ ❑	Stroke	_____	❑ ❑	Thyroid Disease	_____
❑ ❑	Blood Clotting Disorder	_____	❑ ❑	Frequent Cough	_____
❑ ❑	Cancer	_____	❑ ❑	Cold Sores/Fever Blisters	_____
❑ ❑	Radiation Treatment	_____	❑ ❑	Liver Disease	_____
❑ ❑	Chemotherapy	_____	❑ ❑	Epilepsy/Seizures	_____
❑ ❑	Recent Blood Transfusion	_____	❑ ❑	Fainting/Dizziness	_____
❑ ❑	Kidney Problems	_____	❑ ❑	Pacemaker	_____
❑ ❑	Rheumatic Fever	_____	❑ ❑	Headaches	_____
❑ ❑	Arthritis/Sore Joints	_____	❑ ❑	Chemical Dependency	_____

*Women: Do any of the following apply: ❑ Pregnant? (due date: _____) ❑ Trying to get Pregnant? ❑ Nursing

Have you been hospitalized, or have you undergone major surgery, in the past five years? Y / N
If so, please list details and dates:_____

_____

Have you ever had any other serious illness not checked above? If so, discuss:_____

_____

Do you wish to talk to the dentist privately about any problems, questions or concerns? Y / N or staff? Y / N

To the best of my knowledge, all of the preceding answers are true and correct. If there is any change in my health, or if medications change, I will, without fail, inform the doctor immediately.

Patient's Signature: X_____ Date: _____
Reviewed by Doctor _____ Date: _____

DENTAL HEALTH

Primary reason for visit:_____

When was your last dental visit? _____

Name of previous dentist (optional): _____

Date of last full mouth x-rays (8-21 small films or panoramic):_____

For what reason do you usually come to the dentist? _____

Have you ever had any serious problem associated with previous dental treatment? Y / N

If so, explain:_____

Have you ever been diagnosed or treated for Periodontal (Gum) Disease? Y / N

Have you been concerned about bad breath, unpleasant odor or taste in your mouth? Y / N

Do you feel sensitivity with any of your teeth when brushing of flossing them? Y / N

Are there any swelling, growths, inflamed areas or unhealed injuries in/around your mouth? Y / N

Does food catch between your teeth? Where: _____ Y / N

Is any part of your mouth sensitive to temperatures, biting pressure or sweets? Y / N

Have you had orthodonic treatment or bite adjustments? Y / N

Do you have unreplaced missing teeth? Y / N

If so, why have you chosen not to replace them _____

Have you noticed any movement, shifting or change in your teeth? Y / N

Have you had locking or clicking in your jaw, inability to open wide or chew tough foods? Y / N

Do you awaken with the awareness of your teeth and jaws? Y / N

Do you clench or grind your teeth during the day or night? Y / N

Do you have any pain around your eyes, ears, nose, neck or mouth? Y / N

If so, where & how often? _____ Y / N

How often do you get headaches? _____ Neckaches? _____ Y / N

Do you have a history of extensive dental treatment? Y / N

Has it been due to: ❑ new cavities ❑ gum disease ❑ replacement of dental work

Do you want to keep your remaining teeth? Y / N

What level of dental care do you want?

_____ Good "Get-by" care — Do what insurance covers, fix cavities and broken teeth 1 tooth at a time, cleanings every six months.

_____ Better care — Treat needs of multiple teeth plus prevent future problems with state of the art materials, three to six month recare cleanings.

_____ Excellent care — Full mouth reconstruction to ideal, restoring optimal health with a beautiful smile and three to four month recare cleanings, using full porcelain with the best labs.

Please add anything you feel important:_____