## **Patient Health Record**

| □ □ Heart Disease/Surgery □ □ HIV Positive, ARC, or AIDS   | Patie          | nt Name:   | Prefers to be called:              |                                   |  | Date:       |           |
|--|----------------|--|------------------------------------|-----------------------------------|--|-------------|-----------|
| Phone: ( )   | Physi          | cian Name:   |                                    | Physician Loca                    | tion:                                  |             |           |
| Have you received all standard required vaccines?  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:  "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.  YN  |                |  |                                    |                                   |  |             |           |
| Have you ever been instructed to take antibiotics prior to any dental or surgical procedures?  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.  YN Description  Date  YN Description  Date  Heart Murmur  Heart Murmur  Heart Murmur  Heart Murmur  Heart Murmur  Heart Attack/Failure  Atfinicial Joint/Heart Failure  Afficial Joint/Heart Failure  Afficial Joint/Heart Failure  Afficial Joint/Heart Failure  Blood Clotting Disorder  Stroke  Blood Clotting Disorder  Recent Blood Transfusion  Recent Blood Transf |                |  |                                    |                                   |  |             |           |
| Are you currently taking any drugs, medications or herbal supplements?  Please list the medication or herbal supplement and purpose:  "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.  YN  |                |  |                                    |                                   | ntal or surgical procedures            | 2           |           |
| 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.  YN Pescription  Date  YN Pescription  Date  Heart Disease/Surgery  Heart Murmur  Heart Murmur  Heart Murmur  Heart Mitral Valve Prolapse  Heart Attack/Failure  Attricial Joint/Heart Failure  Attricial Joint/Heart Failure  Abnormal Blood Pressure  Abnormal Blood Pressure  Radiation Treatment  Cancer  Radiation Treatment  Chemotherapy  Recent Blood Transfusion  Recent Blood Transfusion  Recent Blood Transfusion  Recent Blood Transfusion  Repeated Blood Fever  Headaches  Attritis/Sore Joints  Heave you been hospitalized, or have you undergone major surgery, in the past five years?  Y/N or staff? Y/N or staff? Y/N or staff? Y/N or staff? Y/N or 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  |                |  |                                    |                                   |  | ;           |           |
| 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.  YN Description  Date  YN Description  Date  Heart Disease/Surgery Heart Murmur Heart Murmur Heart Murmur Heart Murmur Heart Atlack/Failure Heart Disease Heart Atlack/Failure Heart Disease Heart Disease Heart Disease Heart Disease Heart Disease Heart Disease Hea | -              |  | -                                  | •                                 | •                                      |             |           |
| *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  |                | e list the medication of herba                                 |                                    |                                   |  |             |           |
| Do you now have, or have you ever had, any of the following? Please check the appropriate boxes.  YN Description Date YN Description Date Heart Disease/Surgery Heart Murmur Hepatitis (circle) A, B or C Diabetes Heart Attack/Failure Heart Murmur Hepatitis (circle) A, B or C Diabetes Heart Attack/Failure Attificial Joint/Heart Failure Attificial Joint/Heart Failure Abnormal Blood Pressure Blood Clotting Disorder Cancer Cancer Chemotherapy Recent Blood Transfusion Recent Blood Recent Blood Transfusion Recent Blood Rece | Are y          | ou <b>allergic</b> to any drugs, med                           | lications or late                  | x rubber? Plea                    | se list:                               |             |           |
| #Women: Do any of the following apply:   Pregnant? (due date:)   Trying to get Pregnant?   Nursing Have you ever had any other serious illness not checked above? If so, discuss:  | *Due           | to possible complications with<br>ns and/or supplementation at | n anesthetic, I p<br>my next sched | promise to discludes office visit | ose any and all changes o<br>. Initial | r additions | to med-   |
| Heart Disease/Surgery  | Do yo          | ou now have, or have you eve                                   | r had, any of th                   | ne following? P                   | lease check the appropriate            | e boxes.    |           |
| Heart Murmur   Hepatitis (circle) A, B or C   Mitral Valve Prolapse   Diabetes   Tuberculosis   Tuberculosis   Emphysema   Emphysema   Artificial Joint/Heart Failure   Emphysema   Asthma   Abnormal Blood Pressure   Asthma   Thyroid Disease   Frequent Cough   Frequent Cough   Frequent Cough   Cancer   Cold Sores/Fever Blisters   Epilepsy/Seizures   Epilepsy/Seizures   Epilepsy/Seizures   Fainting/Dizziness   Fainting/Dizziness   Headaches   Arthritis/Sore Joints   Headaches   Chemical Dependency   Trying to get Pregnant?   Nursing Have you been hospitalized, or have you undergone major surgery, in the past five years?   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.   | <u>Y N</u>     | <u>Description</u>   | <u>Date</u>                        | <u>Y N</u>                        | <u>Description</u>                     | <u>Date</u> |           |
| Mitral Valve Prolapse  | <u> </u>       | Heart Disease/Surgery  |                                    | <b>.</b>                          | HIV Positive, ARC, or AIDS             |             |           |
| Heart Attack/Failure   |                |  | ****                               |                                   | Hepatitis (circle) A, B or C           |             | _         |
| Artificial Joint/Heart Failure   | I              |  |                                    |                                   |  |             | _         |
| Abnormal Blood Pressure  | I              |  |                                    |                                   |  |             | .         |
| Stroke   | 1              |  |                                    |                                   | - ·                                    |             |           |
| Blood Clotting Disorder  |                |  |                                    |                                   |  | <del></del> |           |
| Cancer   |                |  |                                    |                                   |  |             |           |
| □□ Radiation Treatment □□ Chemotherapy □□ Recent Blood Transfusion □□ Kidney Problems □□ Rheumatic Fever □□ Arthritis/Sore Joints □□ Arthritis/Sore Joints □□ Trying to get Pregnant? □ Nursing Have you been hospitalized, or have you undergone major surgery, in the past five years? □□ Arthritis and dates: □□ Arthritis and dates: □□ 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  □□ Liver Disease □□ Epilepsy/Seizures □□ Fainting/Dizziness □□ Pacemaker □□ Trying to get Pregnant? □ Nursing V / N □ Trying to get Pregnant? □ Nursing I Surgery, in the past five years?  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:   |                |  |                                    |                                   |  |             |           |
| Chemotherapy Recent Blood Transfusion Recent Blood Recent Blood Transfusion Recent Blood Recent B |                |  |                                    |                                   |  |             |           |
| Recent Blood Transfusion Pacemaker P |                |  |                                    |                                   |  |             |           |
| □□ Kidney Problems □□ Pacemaker □□ Headaches □□ Arthritis/Sore Joints □□ 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   | l              |  |                                    |                                   |  |             |           |
| Rheumatic Fever Arthritis/Sore Joints  Headaches 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  | ŀ              |  |                                    |                                   | •                                      |             |           |
| Arthritis/Sore Joints  |                |  |                                    |                                   |  |             |           |
| *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   |                |  |                                    |                                   |  |             |           |
| 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:  |                |  |                                    |                                   |  |             |           |
| 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:   | *Worr          | nen: Do any of the following a                                 | pply: □ Pregna                     | nt? (due date: <sub>.</sub>       | ) 🗅 Trying to get Pr                   | egnant? □   | ı Nursing |
| 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   | Have<br>If so, | you been hospitalized, or have please list details and dates:  | e you undergo                      | ne major surge                    | ery, in the past five years?           |             | 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  | Have           | you ever had any other serio                                   | us illness not o                   | hecked above?                     | ' If so, discuss:                      |             |           |
| 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  |                |  |                                    |                                   |  |             |           |
| health, or if medications change, I will, without fail, inform the doctor immediately.  Patient's Signature: X   | Do yo          | ou wish to talk to the dentist p                               | rivately about a                   | any problems, c                   | uestions or concerns? Y /              | N or staff? | , A\N     |
| Patient's Signature: X Date:   |                |  |                                    |                                   |  | ny change   | ∍ in my   |
| Reviewed by Doctor Date:   | Patie          | nt's Signature: X  |                                    |                                   | Date:                                  |             |           |
|  | Revie          | wed by Doctor  |                                    |                                   | Date:                                  |             |           |

## **DENTAL HEALTH**

| When was your last dental     | visit?   |
|-------------------------------|--|
|                               | optional):   |
|                               | /s (8-21 small films or panoramic):  |
|                               | ually come to the dentist?   |
|                               | ious problem associated with previous dental treatment?  |
| If so, explain:               |  |
| Have you ever been diagno     | osed or treated for Periodontal (Gum) Disease?   |
| Have you been concerned       | about bad breath, unpleasant odor or taste in your mouth?  |
| Do you feel sensitivity with  | any of your teeth when brushing of flossing them?  |
| Are there any swelling, grove | wths, inflamed areas or unhealed injuries in/around your mouth?  |
| Does food catch between y     | our teeth? Where:  |
| Is any part of your mouth se  | ensitive to temperatures, biting pressure or sweets?   |
| Have you had orthodonic tr    | eatment or bite adjustments?   |
| Do you have unreplaced m      | <u> </u>   |
| If so, why have you chosen    | not to replace them  |
| Have you noticed any move     | ement, shifting or change in your teeth?   |
|                               | cking in your jaw, inability to open wide or chew tough foods?   |
| •                             | vareness of your teeth and jaws?   |
|                               | r teeth during the day or night?   |
|                               | nd your eyes, ears, nose, neck or mouth?   |
|                               |  |
| How often do you get head     |  |
| Do you have a history of ex   |  |
| Has it been due to: nev       | •  |
| Do you want to keep your r    |  |
| What level of dental care de  |  |
| 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. |
|                               | el important:  |