Patient Health Record

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

PLEASE FILL OUT BOTH SIDES

DATE

PATIENT'S NAME | MARITAL STATUS | SPOUSE

DATE OF BIRTH | SEX | WEIGHT | OCCUPATION | EMAIL ADDRESS

HOME ADDRESS | ZIP CODE | HOME PHONE

IF CHILD (UNDER 18) NAME OF RESPONSIBLE PERSON | CELL PHONE

PATIENT/PARENT'S EMPLOYER | ADDRESS | PHONE

SPOUSE'S EMPLOYER | ADDRESS | PHONE

NEAREST RELATIVE OR EMERGENCY CONTACT | ADDRESS | PHONE

TYPE OF DENTAL INSURANCE (if applicable) | SOCIAL SECURITY NUMBER

REFERRED BY | MOST CONVENIENT APPOINTMENT TIME

MEDICAL HEALTH

General health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Do you experience shortness of breath after climbing two flights of stairs?.....YES ☐ NO ☐

Name of physician _____ Month/Year of last medical visit _____

Do you currently have any conditions being evaluated by a medical doctor? YES ☐ NO ☐ What for? _____

Have you been hospitalized in the last five years? YES ☐ NO ☐ What for? _____

Are you taking any medications?.....YES ☐ NO ☐ What and for what purpose? _____

Have you ever taken bone-altering drugs by mouth or injection? Bisphosphonates (i.e., Boniva, Fosamax, Actonel) YES ☐ NO ☐

Have you taken corticosteroids within the last year? (i.e., Prednisone, Medrol, Dexamethasone).....YES ☐ NO ☐

Have you ever been treated for: (IF YES, PLEASE EXPLAIN ON BACK)

Heart disease.....YES ☐ NO ☐		Heart valve replacement.....YES ☐ NO ☐	
Rheumatic fever .....YES ☐ NO ☐		Joint replacement.....YES ☐ NO ☐	
Abnormal blood pressure.....YES ☐ NO ☐		Asthma.....YES ☐ NO ☐	
Congenital heart defects.....YES ☐ NO ☐		Tuberculosis or lung disease.....YES ☐ NO ☐	
Anemia.....YES ☐ NO ☐		Persistent cough.....YES ☐ NO ☐	
Heart attack.....YES ☐ NO ☐		Hepatitis.....YES ☐ NO ☐	
Stroke.....YES ☐ NO ☐		HIV/AIDS.....YES ☐ NO ☐	
Bleeding disorders.....YES ☐ NO ☐		Colitis.....YES ☐ NO ☐	
Arthritis.....YES ☐ NO ☐		Leukemia.....YES ☐ NO ☐	
Diabetes.....YES ☐ NO ☐		Cancer.....YES ☐ NO ☐	
Glaucoma .....YES ☐ NO ☐		Radiation therapy to head/neck.....YES ☐ NO ☐	

Have you been advised to take antibiotics before dental treatment?.....YES ☐ NO ☐

Are you allergic to: Latex ☐ Penicillin ☐ Local injected anesthetics ☐ Other medications ☐ _____

Do you have prolonged bleeding? YES ☐ NO ☐ Are you subject to fainting spells?.....YES ☐ NO ☐

(women) Using birth control?.....YES ☐ NO ☐ Are you pregnant? YES ☐ NO ☐ How many weeks? _____

PLEASE TURN TO OTHER SIDE

DENTAL HEALTH

Reason for visit: _____

When was your last dental visit? _____

Have you ever had any serious problem associated with previous dental treatment? ..... Yes ☐ No ☐

If so, explain: _____

_____

How often do you brush your teeth? _____

What texture brush do you use? SOFT ☐ MEDIUM ☐ HARD ☐ NYLON ☐ NATURAL ☐

How often do you floss? _____

Do your gums bleed while brushing? ..... Yes ☐ No ☐

Do your gums bleed when flossing? ..... Yes ☐ No ☐

Do you avoid brushing any part of your mouth because of pain? ..... Yes ☐ No ☐

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with:

a) hot foods or liquids, i.e., soup, coffee, tea, etc.? ..... Yes ☐ No ☐

b) cold foods or liquids, i.e., ice cream, cold fruit, etc.? ..... Yes ☐ No ☐

c) sweets, i.e., candy, fruit, sweet desserts, etc.? ..... Yes ☐ No ☐

d) sours, i.e., lemons, limes, grapefruit, etc.? ..... Yes ☐ No ☐

Do you feel pain to any of your teeth when brushing or flossing them? ..... Yes ☐ No ☐

Do you chew on only one side of your mouth? ..... Yes ☐ No ☐

If yes, explain: _____

_____

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

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

Do your jaws ever feel tired? ..... Yes ☐ No ☐

Do you wear dentures? ..... Yes ☐ No ☐

Do you usually have many cavities? ..... Yes ☐ No ☐

Do you lose fillings or break fillings? ..... Yes ☐ No ☐

Do you gag easily? ..... Yes ☐ No ☐

Are you familiar with the term "preventive dentistry"? ..... Yes ☐ No ☐

Do you have any unusual fear of dental treatment? ..... Yes ☐ No ☐

Please add anything you feel is important: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Patient signature)