

# Patient Health Record

In order to help me render 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 \_\_\_\_\_

PREFERRED NAME \_\_\_\_\_

NAME OF RESPONSIBLE ADULT \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

SPOUSE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SEX \_\_\_\_\_

WEIGHT \_\_\_\_\_

EMAIL ADDRESS (for appointment reminders) \_\_\_\_\_

CELL PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

PATIENT/PARENT'S EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

WHAT DO YOU DO FOR FUN (HOBBIES)? \_\_\_\_\_

ONE THING YOU ARE PASSIONATE ABOUT IN LIFE \_\_\_\_\_

NEAREST RELATIVE OR EMERGENCY CONTACT \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

TYPE OF DENTAL INSURANCE (if applicable) \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

## 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? (What for? \_\_\_\_\_).....YES  NO

Have you been hospitalized in the last five years? .....(What for? \_\_\_\_\_).....YES  NO

List ALL current medications: \_\_\_\_\_

(continue on back) \_\_\_\_\_

Have you ever taken bone-altering medications? Bisphosphonates (i.e., Boniva, Fosamax, Actonel, Prolia).....YES  NO

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

## Which of these conditions apply to you: (IF YES, PLEASE EXPLAIN ON BACK)

Heart disease.....YES  NO  \*Prior Heart Infection .....YES  NO

\*Pacemaker.....YES  NO  \*Congenital Heart Defect.....YES  NO

Abnormal blood pressure.....YES  NO  \*Heart Valve Replacement.....YES  NO

Heart Attack.....(WHEN? \_\_\_\_\_).....YES  NO  \*Joint Replacement...(WHEN? \_\_\_\_\_).....YES  NO

Stroke.....(WHEN? \_\_\_\_\_).....YES  NO  \*Diabetes...(CIRCLE: Type 1, Type 2).....YES  NO

\*Bleeding Disorders.....YES  NO  \*Colitis.....YES  NO

\*Taking Blood Thinners.....YES  NO  \*Leukemia.....YES  NO

Arthritis.....YES  NO  \*Current Cancer.....YES  NO

Asthma...(Ever Hospitalized? \_\_\_\_\_)..YES  NO  \*Radiation therapy to head/neck.....YES  NO

Tuberculosis or Lung Disease.....YES  NO  \*Hepatitis.....(A/B/C? \_\_\_\_\_).....YES  NO

Persistent Cough.....YES  NO  \*HIV/AIDS.....YES  NO

Are you currently required by a medical doctor to take antibiotics before dental treatment?.....YES  NO

Are you allergic to: Penicillin  Sulfa  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? .....(# of weeks? \_\_\_\_\_).....YES  NO

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, please explain: \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

What tooth brush do you use? MANUAL  ELECTRIC  Bristle Texture: SOFT  MEDIUM  HARD

How often do you floss? \_\_\_\_\_

Do your gums bleed while brushing?.....YES  NO

Do your gums bleed while flossing?.....YES  NO

Do your gums feel tender or swollen?.....YES  NO

Do you feel pain in any of your teeth when brushing or flossing them?.....YES  NO

Do you avoid brushing any part of your mouth because of pain?.....YES  NO

If yes, what part? \_\_\_\_\_

Do you chew on only one side of your mouth?.....YES  NO

If yes, explain: \_\_\_\_\_

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 usually have many cavities?.....YES  NO

Do you regularly drink liquids other than water? (Soda, Sports Drinks, Energy Drinks, Coffee).....YES  NO

Do you clench or grind your teeth while sleeping or during the day?.....YES  NO

Do your jaws ever feel tired?.....YES  NO

Do you easily lose or break fillings?.....YES  NO

Do you frequently experience migraines or headaches upon waking up in the morning?.....YES  NO

Do you frequently experience migraines or headaches during the day?.....YES  NO

Do you snore?.....YES  NO

Does your significant other say you snore?.....YES  NO

Do you experience day-time tiredness or fatigue?.....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

Do you need sedation for dental anxiety (gas, pill, IV)?.....YES  NO

Do you have need for tooth replacement?.....YES  NO

If you wear dentures or partial dentures, are you looking to enhance their chewing capacity?.....YES  NO

Do you have interest in changing the appearance of your smile?.....YES  NO

Other Medications, Details on Medical Conditions, or ANYTHING ELSE YOU FEEL IS IMPORTANT: \_\_\_\_\_

\_\_\_\_\_  
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\_\_\_\_\_  
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**PLEASE SIGN**  $\Rightarrow$  x \_\_\_\_\_  
(Patient Signature)