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: _____

_____

_____

_____

_____

_____

_____

_____

PLEASE SIGN ⇨ x_____

(Patient Signature)