Patient Health Record

PLEASE PRINT

Date _____

Name _____ Soc. Sec. No. _____
(LAST) (FIRST) (MIDDLE)

Name you wish to be called _____

Home Address _____
(STREET) (CITY) (STATE) (ZIP)

Home Telephone _____ Business Telephone _____ Date of Birth _____

Sex _____ Height _____ Weight _____ Single ☐ Married ☐ Widow ☐ Divorced ☐

Occupation _____ Place of Employment _____

Spouse's Name _____ Date of Birth _____ Business Phone _____

Spouse Occupation _____ Place of Employment _____

Dental Insurance Company _____ Policy Number _____

Closest Relative _____ Telephone No. _____

Who Recommended Our Office? _____ Most Convenient Appointment Time _____

Person Responsible For Account _____ Driver's License Number _____ State _____

MEDICAL HEALTH

Name and address of physician _____

Are you taking any medication now? Yes ☐ No ☐ For what purpose? _____

List Medications _____ _____

_____ _____

Have you ever been treated for:

Heart disease	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Anemia	Yes ☐	No ☐
Heart attack	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Heart valve defect	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Heart valve replacement	Yes ☐	No ☐	Sinus trouble or hay fever	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐	Cough	Yes ☐	No ☐
Hip replacement	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	AIDS	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Nervous disorders	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Lung disease	Yes ☐	No ☐	Psychiatric treatment	Yes ☐	No ☐
Venereal disease	Yes ☐	No ☐	Cancer	Yes ☐	No ☐

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

Have you ever had radiation treatments?		Yes ☐	No ☐
Are you subject to prolonged bleeding?		Yes ☐	No ☐
Do you have trouble sleeping?		Yes ☐	No ☐
Do you have problems with digestion?		Yes ☐	No ☐
Do you smoke?	Yes ☐ No ☐	How much?	_____
Have you had any serious operations in the last 5 years?		Yes ☐	No ☐
Are you subject to fainting spells?		Yes ☐	No ☐
Do you have excessive urination and/or thirst?		Yes ☐	No ☐
Have you ever been told to take antibiotics before dental treatment?		Yes ☐	No ☐

(Women Only)

Are you pregnant?	Yes ☐ No ☐	How long?	_____
Do you have any problems associated with your menstrual period?		Yes ☐	No ☐
Do you have a poor appetite?		Yes ☐	No ☐

DENTAL HEALTH

Reason for visit_____

When was your last dental visit?_____

Name and address of previous dentist_____

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

If so, explain:_____

Do you have periodic dental checkups? ..... Yes ☐ No ☐

When did you last have your teeth professionally cleaned?_____

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 twings of pain when your teeth come in contact with: Hot ☐ Cold ☐ Sweets ☐ Sours ☐

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

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

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

Are you usually nervous during dental visits? ..... Yes ☐ No ☐

Do you prefer local anesthetic during dental visits? ..... Yes ☐ No ☐

Do you gag easily? ..... Yes ☐ No ☐

Do you think you eat well-balanced meals? ..... Yes ☐ No ☐

How do you feel about the general condition of your teeth and gums?_____

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

Do you have difficulty or pain, or both, when opening your mouth, as for instance, when yawning? ..... Yes ☐ No ☐

Does your jaw get "stuck," "locked," or "go out"? ..... Yes ☐ No ☐

Do you have difficulty or pain, or both, when chewing, talking, or using your jaws? ..... Yes ☐ No ☐

Are you aware of noises in the jaw joints? ..... Yes ☐ No ☐

Do you have pain in or about the ears, temples, or cheeks? ..... Yes ☐ No ☐

Does your bite feel uncomfortable or unusual? ..... Yes ☐ No ☐

Do you have frequent headaches? ..... Yes ☐ No ☐

If yes, how often? _____

Have you had a recent injury to your head, neck, or jaw? (Automobile accident) ..... Yes ☐ No ☐

Have you previously been treated for a jaw joint problem? ..... Yes ☐ No ☐

If so, when?_____

Do you have arthritis? ..... Yes ☐ No ☐

Do you have any muscle or joint problems? ..... Yes ☐ No ☐

Have you even been treated for a temporomandibular disorder? ..... Yes ☐ No ☐

Please add anything you feel is important:_____

Medical history updated with no changes

_____ (Patient Signature)