PATIENT HEALTH RECORD

Date_____ Patient Number_____
Name Last _____ First _____Middle____
Home Address: Street _____
City, State &Zip_____
Employer's Name_____
Phone Home _____ Business _____Cell_____
Date of Birth_____Sex_____Height_____Weight_____
Occupation_____
Marital Status Single Married Widowed Separated Divorced
Social Security Number_____
Spouse's Name_____
Referred By_____
Reason for Your Visit_____
Name and Phone Number we may call in case of Emergency_____
Name and Phone Number of Physician and or Specialist_____

CURRENT OR PAST DISEASES, CONDITIONS OR PROBLEMS

Please place an x in the correct box. Additional space is provided for an explanation.

Cardiovascular

Yes No
☐ ☐ High Blood Pressure_____
☐ ☐ Coronary Artery Disease (Angina) _____
☐ ☐ Heart Murmur_____
☐ ☐ Rheumatic Fever_____
☐ ☐ Mitral Valve Prolapse_____
☐ ☐ Congenital Heart Lesion_____
☐ ☐ Heart Surgery_____

Blood Conditions

☐ ☐ Blood Transfusion_____
☐ ☐ Anemia_____
☐ ☐ Sickle Cell Disease_____
☐ ☐ Prolonged Bleeding_____
☐ ☐ Leukemia_____

Immuniosupressed Conditions

☐ ☐ Aids_____
☐ ☐ Lupus_____
☐ ☐ Fibromyalgia _____
☐ ☐ Multiple Sclerosis_____

Cancer

Yes No

☐ ☐ Radiation Treatment_____

☐ ☐ Chemotheraphy_____

☐ ☐ Surgery_____

Gastrointestinal/Endocrine

☐ ☐ Ulcer, Colitis_____

☐ ☐ Liver_____

☐ ☐ Hepatitis (A, B, C) _____

☐ ☐ Diabetes (type 1, 2) _____

Neurological

☐ ☐ Psychiatric Treatment_____

☐ ☐ Stroke_____

☐ ☐ Parkinsons_____

☐ ☐ Epilepsy/Seizures_____

☐ ☐ Fainting_____

☐ ☐ Visual/Hearing Impaired_____

Respiratory

☐ ☐ Atmospheric Allergies_____

☐ ☐ Asthma_____

☐ ☐ Tuberculosis_____

☐ ☐ Emphysema_____

Muscular/Skeletal

☐ ☐ Arthritis_____

☐ ☐ Osteoporosis_____

☐ ☐ Joint Replacement_____

Medical Conditions/Medications

☐ ☐ Immunosuppressant Drugs_____

☐ ☐ Allergies/ Reactions to Medications_____

☐ ☐ Metal/Latex Allergy_____

☐ ☐ Tobacco use? Form/Frequency_____

☐ ☐ Diagnostic X-Rays (Not Dental) Date/Reason_____

☐ ☐ Chemical Dependency_____

Kidney Disease (yes or no) _____

Dialysis/Transplant (yes or no) _____

Autoimmune Disease (yes or no) _____

Pregnant (yes or no), if yes how many months _____

Are you taking any medications now? (Please list) _____

_____

Do you require antibiotics before dental treatment? (yes or no) _____

Are you taking or scheduled to take either oral or IV bisphosphonates (Fosamax, Actonel or Zometa)? (yes or no) _____

Are you allergic or have reacted adversely to local anesthetic (ex. Novocain)? (yes or no)

Dental Health

When was your last dental cleaning? _____
How do you feel about your teeth? _____
Are you satisfied with the appearance of your teeth? _____
How often do you brush your teeth? _____
How often do you floss? _____
Have you had a serious injury to your head or mouth? _____

Yes	No	
☐	☐	Do you experience bad breath?
☐	☐	Do you experience dry mouth?
☐	☐	Do your gums bleed while brushing or flossing?
☐	☐	Are your teeth sensitive to hot, cold, sweets or pressure? _____
☐	☐	Do you grind or clench your teeth?
☐	☐	Do you gag easily?
☐	☐	Are you apprehensive (nervous) about dental treatment?

Consent

I certify that I have read and understand the above questions and have accurately answered them. I understand that providing incomplete or incorrect information can be dangerous to my health.

Patient Signature (Parent of Child): _____
Date: _____