

# PATIENT HEALTH RECORD

Date \_\_\_\_\_ Email Address: \_\_\_\_\_

Name : \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
(last) (first) (initial)

Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone : \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Single \_\_\_\_\_

Closest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

**MEDICAL HEALTH:**

Name and Address of Physician: \_\_\_\_\_

Have you been under a physician's care during the past 2 years? \_\_\_\_\_ For? \_\_\_\_\_

Have you been treated in a hospital in the past 2 years? \_\_\_\_\_ For? \_\_\_\_\_

Have you ever had major surgery? \_\_\_\_\_

If female: Are you taking hormone's or birth control? \_\_\_\_\_ Are you pregnant or nursing? \_\_\_\_\_

Have you ever had a blood test for hepatitis? \_\_\_\_\_ Were you vaccinated? \_\_\_\_\_

Have you had cankers or cold sores on your lips, tongue, gums, or body? \_\_\_\_\_

Are you now taking or have you taken any prescription drugs during the past year? \_\_\_\_\_ List: \_\_\_\_\_

\_\_\_\_\_ Are you allergic to:

Penicillin  Codeine  Local Anesthetics  Other \_\_\_\_\_

Are you taking or have you ever taken any of the following medications (Circle): ACTONEL, FOSOMAX, BONIVA, SKELID, DI-DRONEL, AREDIA, ZOMETA, BONEFOS

Have you had or do you now have

	yes	no		yes	no
Abnormal blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints.....	<input type="checkbox"/>	<input type="checkbox"/>	Polio.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged cough.....	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Phychiatric treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Drug dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease.....	<input type="checkbox"/>	<input type="checkbox"/>

Have you any disease, condition, or problem not previously listed? \_\_\_\_\_

\_\_\_\_\_

## DENTAL HEALTH

When was your last dental visit? \_\_\_\_\_

How often did you see your dentist? \_\_\_\_\_

Are you having any dental problems that require immediate attention? \_\_\_\_\_

Do you have any of the following cause tooth discomfort? Hot \_\_\_\_\_ Cold \_\_\_\_\_ Sweets \_\_\_\_\_ Chewing \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_ Water Jet? \_\_\_\_\_

Do your gums bleed while cleaning? \_\_\_\_\_

Do your gums ever feel tender or swollen? \_\_\_\_\_

Have you had periodontal treatment? \_\_\_\_\_ When? \_\_\_\_\_

Do you clench or grind your teeth? \_\_\_\_\_

Do your jaws ever feel tired or ache? \_\_\_\_\_ Click or pop? \_\_\_\_\_

Can you chew on both sides of your mouth? \_\_\_\_\_ Comfortably? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_ Earaches? \_\_\_\_\_

Have you ever had orthodontic treatment (braces)? \_\_\_\_\_ When? \_\_\_\_\_

Do you lose fillings or break fillings? \_\_\_\_\_

Do you usually have many cavities? \_\_\_\_\_

Do you have loose teeth? \_\_\_\_\_ Cracked or broken teeth? \_\_\_\_\_

Do you have any noticeable wear on your teeth? \_\_\_\_\_ Food traps? \_\_\_\_\_

Do you have any missing teeth? \_\_\_\_\_ Have they been replaced? - \_\_\_\_\_

If so, how? Fixed bridge \_\_\_\_\_ Removeable partial \_\_\_\_\_ Full denture \_\_\_\_\_ Dental Implant \_\_\_\_\_

Are you comfortable with the replacement? \_\_\_\_\_ Please describe \_\_\_\_\_

How do you feel about the appearance of your smile? \_\_\_\_\_

Have you ever had any cosmetic dentistry done to improve your appearance? \_\_\_\_\_

If yes, are you pleased with the result? \_\_\_\_\_ Please comment \_\_\_\_\_

Have you ever had an unpleasant dental experience? \_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_

Signature \_\_\_\_\_

