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Patient Health Record

In order to help us render the proper care to you, please be kind enough to answer the following questions. Thank you.

Name: _____ DOB: _____
LAST FIRST MIDDLE NICKNAME

Address: _____
STREET CITY STATE ZIP

Phone: _____ Email: _____

☐ Male ☐ Female ☐ Other SS # _____ Height: _____ Weight: _____

Are you: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced Contact Preference: ☐ Text ☐ Email

Emergency Contact: _____
NAME PHONE

Dental Insurance: _____ Subscriber: _____

Employer: _____
NAME PHONE

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Pharmacy: _____

Primary Care Physician: _____
NAME PHONE

Who can we thank for referring you to our practice? _____

1. Have you been hospitalized in the past 5 years? ☐ Yes ☐ No If yes, where? _____
   For what? _____
2. Date of Last Complete Physical: _____ Date of Last Dental Visit: _____
   Previous Dentist: _____
   NAME PHONE
3. Are you taking any medication by prescription or over the counter for any reason? ☐ Yes ☐ No
   If yes, what medication and for what purpose? _____
   _____
4. Have you ever had radiation treatments? ☐ Yes ☐ No
5. Do you routinely desire Local Anesthetics for dental work? ☐ Yes ☐ No
6. Are you allergic to:
   ☐ Penicillin ☐ Any Medical Procedure ☐ Codeine
   ☐ Erythromycin ☐ Any Particular Foods ☐ Aspirin
   ☐ Tetracycline ☐ Local Anesthetics ☐ **No Known Allergies**
   Other Medication: _____
7. Are you subject to: Abnormal bleeding from a cut? ☐ Yes ☐ No Fainting spells? ☐ Yes ☐ No
8. Do you have excessive urination or thirst? ☐ Yes ☐ No
9. **Women** Are you pregnant? ☐ Yes ☐ No If yes, who is your OB/GYN? _____
10. Are you now or have you ever been on any special diet? ☐ Yes ☐ No

(*Please complete the reverse side*)

11. Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____

12. Have you ever undergone therapy for emotional problems or depression? ☐ Yes ☐ No

13. Does your jaw click, crack, lock or hurt when you open or close your mouth? ☐ Yes ☐ No

14. Do you suffer from headaches or migraines frequently? ☐ Yes ☐ No

15. Do you have pain in or near your ears? ☐ Yes ☐ No

16. Do you have any unhealed sores or inflamed areas in or around your mouth? ☐ Yes ☐ No

17. Do you clench or grind your teeth during the day or night? ☐ Yes ☐ No If yes, when? _____

18. Has a physician ever informed you that you had or treated you for any of the following? *Please Circle*

Heart Disease / Heart Ailments	Yes	No	Hay Fever	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No
Abnormal Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Ulcers, Intestinal Disease	Yes	No	Cough (Persistent)	Yes	No
Tuberculosis or Lung Disease	Yes	No	Hepatitis or Yellow Jaundice	Yes	No
Diabetes	Yes	No	Arthritis or Rheumatism	Yes	No
Epilepsy or Convulsions	Yes	No	Stroke	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No
Congenital Heart Disease	Yes	No	AIDS/HIV+	Yes	No
Thyroid Condition	Yes	No	Mononucleosis	Yes	No
Blood Disease	Yes	No	Venereal Disease	Yes	No
Tumors or Growths	Yes	No	Malignancies	Yes	No
Heart Murmur	Yes	No	Liver Disease	Yes	No

19. Do your gums bleed easily? ☐ Yes ☐ No If yes, in any particular place? _____

20. Have you ever had instruction on the correct method of brushing your teeth? ☐ Yes ☐ No

21. Frequency of brushing: _____ Frequency of flossing: _____

22. Are your teeth sensitive to scaling? ☐ Yes ☐ No

23. Have you ever had instruction on the care of your gums? ☐ Yes ☐ No

24. Do you chew on only one side of your mouth? ☐ Yes ☐ No If so, why? _____

25. When (if ever) was your last full mouth series of x-rays taken? _____

If within the past 5 years, are they available to our office? ☐ Yes ☐ No

26. Is any part of your mouth sensitive to: Pressure Hot Cold Sweets None

If so, where? _____

27. Do you have a primary dental complaint at this moment? ☐ Yes ☐ No If so, what? _____

28. Are you pleased with your smile? ☐ Yes ☐ No 29. Do you gag easily? ☐ Yes ☐ No

30. Have you ever had a dental experience that upset you? ☐ Yes ☐ No

31. Do your children routinely get any of the following?

☐ Fluoride supplements ☐ Fluoride treatments in the dental office ☐ Fluoride rinse programs at school

32. Do you assist in the brushing and flossing of your children's teeth? ☐ Yes ☐ No

33. Have you had your blood pressure checked recently? ☐ Yes ☐ No

34. Do you have any history of joint or heart valve surgery or replacement? ☐ Yes ☐ No

35. **Is there anything you feel we should know regarding your dental care that was not addressed by this questionnaire?** _____

_____

Patient / Guardian Signature _____ **Dr. Signature** _____