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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.

1. Name: _____ Date: _____
   LAST FIRST MIDDLE NICKNAME
2. Mailing Address: _____ Phone: _____
   STREET CITY STATE ZIP
3. Contact Preference: ☐ Text _____ ☐ Email _____
4. Date of Birth:_____ ☐ Male ☐ Female Height:_____ Weight:_____
5. ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced SS #_____
6. Employer: _____ Phone: _____
   STREET CITY STATE ZIP
7. Responsible Party: _____
   NAME ADDRESS PHONE
8. Dental Insurance Co.: _____ Most Convenient Appointment Time:_____
9. Who can we thank for referring you to our practice?_____
10. General Health (Please Check): ☐ Excellent ☐ Good ☐ Fair ☐ Poor
11. Physician: _____ Phone: _____
12. Have you been hospitalized in the past 5 years? ☐ Yes ☐ No If yes, where?_____
    For what?_____
13. Date of Last Complete Physical:_____ Date of Last Dental Visit:_____
    Previous Dentist:_____
    NAME ADDRESS PHONE
14. Are you taking any medication by prescription or over the counter for any reason? . . . . . ☐ Yes ☐ No
    If yes, what medication and for what purpose? _____
15. Have you ever had radiation treatments? . . . . . ☐ Yes ☐ No
16. Do you routinely desire Local Anesthetics (Novacaine) for dental work? . . . . . ☐ Yes ☐ No
17. Are you allergic to:
    ☐ Penicillin ☐ Any Medical Procedure ☐ Codeine
    ☐ Erythromycin ☐ Any Particular Foods ☐ Aspirin
    ☐ Tetracycline ☐ Local Anesthetics
    ☐ Other Medication: _____
18. Are you subject to: Abnormal bleeding from a cut? ☐ Yes ☐ No Fainting spells? ☐ Yes ☐ No
19. Do you have excessive urination or thirst? . . . . . ☐ Yes ☐ No
20. (Women) Are you pregnant? ☐ Yes ☐ No If yes, who is your OB/GYN? _____
21. Are you now or have you ever been on any special diet? . . . . . ☐ Yes ☐ No
22. Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____

(*Please complete the reverse side*)

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

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

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

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

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

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

29. Has a physician ever informed you that you had or treated you for any of the following?

Heart Disease or 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, Stomach or 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

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

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

Frequency of brushing:_____ Frequency of flossing:_____

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

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

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

34. 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

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

If so, where? _____

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

37. Are you pleased with your smile? . . . . . ☐ Yes ☐ No

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

39. Do you gag easily? . . . . . ☐ Yes ☐ No

40. Do your children routinely get any of the following? [*Check if yes*] ☐ Fluoride supplements
☐ Fluoride treatments in the dental office ☐ Fluoride rinse programs at school

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

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

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

Is there anything you feel we should know regarding your dental care that was not addressed by this questionnaire? ☐ Yes ☐ No
If yes, what? _____

Please sign:

Patient's or Guardian's Signature_____ **Doctor's Signature**_____