PATIENT HEALTH RECORD

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In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation. Please fill out in ink.

DATE _____

NAME _____ (LAST) _____ (MIDDLE) _____ (FIRST) Phone: _____

DATE OF BIRTH _____ SEX _____ HEIGHT _____ WEIGHT _____ OCCUPATION _____ Phone: _____

1. How is your General Health? (Please check)
   ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
2. Name and address of physician _____
   Last complete physical? _____
3. Are you taking any medication now? ☐ YES ☐ NO For what purpose? _____
4. Please list all medications that you are now taking, and the dosages you take. _____
5. Do you have any prosthetic joints (artificial hip, knee, etc.)? _____
6. Please check the appropriate one:

Have you had any blood transfusions? ☐ YES ☐ NO	Do you wear a heart pacemaker? ☐ YES ☐ NO	Do you use tobacco in any form? ☐ YES ☐ NO
Do you have any problems with your body's immune (defense) system? ☐ YES ☐ NO	Have you ever been treated (other than diagnostic) with x-ray? ☐ YES ☐ NO	Have you lost or gained significant mounts of weight in the last year? ☐ YES ☐ NO
Please describe: _____	Do you have excessive urination and/or thirst? ☐ YES ☐ NO	Have you been tested for AIDS ☐ YES ☐ NO
Can you donate blood? ☐ YES ☐ NO	Are you pregnant? (women) ☐ YES ☐ NO	Are you subject to prolonged bleeding? ☐ YES ☐ NO
If not, why not? _____	How long? _____	Are you subject to fainting spells? ☐ YES ☐ NO

7. Are you allergic to any medications? _____
   ☐ PENICILLIN ☐ CODEINE ☐ LOCAL INJECTED ANESTHETICS ☐ Latex
8. Have you ever been treated for: (Please check)

AIDS ☐ YES ☐ NO	Anemia ☐ YES ☐ NO	Sinus trouble ☐ YES ☐ NO
Heart disease ☐ YES ☐ NO	Congenital heart lesions ☐ YES ☐ NO	Cough ☐ YES ☐ NO
Rheumatic fever ☐ YES ☐ NO	Any blood disease ☐ YES ☐ NO	Hepatitis ☐ YES ☐ NO
Abnormal blood pressure ☐ YES ☐ NO	Respiratory disease ☐ YES ☐ NO	Arthritis ☐ YES ☐ NO
Ulcers ☐ YES ☐ NO	ARC (AIDS-Related Complex) ☐ YES ☐ NO	Stroke ☐ YES ☐ NO
Tuberculosis or Lung disease ☐ YES ☐ NO	Heart murmur ☐ YES ☐ NO	Glaucoma ☐ YES ☐ NO
Diabetes ☐ YES ☐ NO	Jaundice ☐ YES ☐ NO	Any liver disease ☐ YES ☐ NO
Epilepsy ☐ YES ☐ NO	Asthma or hay fever ☐ YES ☐ NO	Stomach or intestinal disease ☐ YES ☐ NO

9. What is your blood pressure? _____
10. Please list all major operations or surgeries that you have had performed: _____

I hereby certify that the health information given on this form is complete and correct to the best of my knowledge.

Signature: _____ Date: _____

Witness: _____

LEAVE THE FOLLOWING STATEMENT UNSIGNED WHEN FIRST COMPLETING FORM.
I certify that the updated information on this form is complete and correct.

Signature: _____ Date: _____

Witness: _____

DENTAL HEALTH HISTORY

1. Reason for visit today? _____
2. When was your last dental visit? _____
3. Check which one of the following statements best describes the type of dentistry you want for yourself:
   1. I want to have necessary dental care to keep my mouth comfortable and out of pain.
   2. I want dental care that maintains my present teeth in good health.
   3. I want dental care that maintains my present teeth in good health and replaces any missing teeth or teeth that I may have to lose in the future.
   4. I want the highest quality of dental care available to prevent dental problems, restore my remaining teeth to optimum health, and replace any teeth that are missing or that I may lose.
4. What do you think is the present health of your teeth and related tissue (gums, bone support, et.)?
   ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
5. What is the level of dental treatment that you think you have received in the past?
   ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
6. Have you ever had any serious problem associated with previous dental treatment? _____ If so, explain: _____
   _____
7. Are you familiar with the term, "preventive dentistry?" _____
8. How do you feel about the appearance of your teeth?
   ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
9. Are you familiar with the term, "cosmetic dentistry?" _____
10. Would you desire dental treatment to improve the appearance of your teeth?
    ☐ YES ☐ NO ☐ MAYBE
11. How often do you brush your teeth? _____
12. What texture brush do you use?
    ☐ SOFT ☐ MEDIUM ☐ HARD ☐ NYLON ☐ NATURAL
13. How often do you floss? _____
14. Do your gums bleed while brushing? _____
15. Do your gums bleed while flossing? _____
16. Do you avoid brushing any part of your mouth because of pain? ☐ YES ☐ NO If yes, what part? _____
17. Do you feel twinges of pain when your teeth come in contact with:
    a). hot foods or liquids, i.e., soup; coffee, tea, etc.? _____
    b). cold foods or liquids, i.e., ice cream, cold fruit, etc.? _____
    c). sweets, i.e., candy, fruit, sweet desserts, etc.? _____
    d). sours, i.e., lemons, limes, grapefruit, etc.? _____
18. Do you feel pain to any of your teeth when brushing or flossing them? _____
19. Do you chew on only one side of your mouth? ☐ YES ☐ NO If yes, explain: _____
20. Do your gums feel tender or swollen? _____
21. Do you clench or grind your jaws while sleeping or during the day? _____
22. Do your jaws ever feel tired? _____
23. Do you wear dentures? _____
24. Do you usually have many cavities? _____
25. Do you lose fillings or break fillings? _____
26. Do you gag easily? _____
27. Please add any other information you feel is pertinent concerning your dental history. _____
    _____
    _____
    _____