

PATIENT HEALTH RECORD

Patient Name _____ **Spouses name**

Address

Phone#: **Home** _____ **Work** _____ **Cell**

E-mail address _____ **Birthdate:**
Y__ M__ D__

Employer/School _____ **Parents Name**

Insurance Co. _____

Whom may we thank for referring you? _____

MEDICAL HEALTH

Name and phone # of family doctor _____

Have you been under a doctor's care during the past 2 years? Y N For: _____

Have you been treated in a hospital in the past 2 years? Y N For: _____

Have you ever had major surgery? Y N For: _____

If female: Are you taking hormones or birth control? Y N Are you pregnant or nursing? Y N

Have you ever had a blood test for hepatitis? Y N Were you vaccinated? Y N

Have you had cankers or core sores on your lips, tongue, gums or body? Y N

Are you now taking or have you taken any prescription drugs during the past year? Y N

If yes, for: _____

Are you allergic to: penicillin codeine local anaesthetic latex none other _____

Have you had or do you now have any of the following:

Blood, Heart and Circulatory Disorders_ Yes No Debilitating/Infectious Disorders Yes No

Anemia

Cancer

Haemophilia

Chemotherapy

Bleeding easily

Radiation Therapy

Blood transfusions

Hepatitis/Jaundice

Heart Disease

Drug dependency

Artificial Heart Valves

Psychiatric problems

Congenital Heart Defects

HIV

Rheumatic heart disease
Heart murmur
Angina, heart attack, chest pain
High blood pressure
Stroke or blood clots

Other Disorders

Malignant Hypothermia
Thyroid/Adrenal disease
Diabetes
Kidney disease
Venereal disease/Herpes

Respiratory Disorders

.....
Lung disease
..... Tuberculosis
Skin rash, hives, skin disorder
Emphysema
disorder
Asthma or hay fever
Pneumonia or pleurisy
Sinus trouble

Rheumatoid arthritis

Stomach or bowel

Ear disorders/dizziness
Eye disorders
Epilepsy or seizures
Fainting spells

Miscellaneous

Pins, plates, replacement joints
Organ transplant
Pacemaker

Do you have any disease, condition or
problem not previously listed?

DENTAL HEALTH

When was your last dental visit? _____ last cleaning? _____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do 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? Y N If so, when? _____

Do you clench or grind your teeth? _____

Do your jaw 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 filling break fillings? _____

Do you usually have many cavities? _____

Do you have any 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? (circle) Fixed bridge removable 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 please with the result? Please comment _____

Have you ever had an unpleasant dental experience? _____

Have you ever been sedated for a dental appointment? _____

Are you aware of bad breath or a bad taste in your mouth? _____

Please add anything you feel is important for us to know:

This is to certify that I, the undersigned, consent to the performing of the dental procedures AS AGREED UPON to be necessary or advisable, including the use of local or conscious sedation.

I will assume all responsibility for fees associated with these procedures.

Patient (guardian) signature: _____ (date) _____