Patient Health Record

Name _____ Date of Birth ____/____/_____ SSN _____ - ____ - _____

Medical History

Are you currently under the care of a physician? …… Y _____ N _____

Name of physician _____ Phone _____

Address _____

Are you currently taking any medication? …… Y_____ N _____

If yes, what, and for what purpose? _____

Are you allergic to: ____ penicillin ____ local anesthetics _____latex _____ other

Have you had x-rays of any kind in the last 5 years? …… Y_____ N_____

Do you: _____ smoke _____ chew tobacco ____ use alcohol ____ use drugs for recreation

Have you ever been tested / treated for: _____ hepatitis _____HIV/AIDS _____ Alcohol or drug abuse

Have you ever been told to take medication (antibiotics) before dental treatment? ……. Y_____ N_____

Are you currently taking a daily aspirin or blood thinner? ……Y_____ N_____

Women: Are you pregnant? _____ Nursing? _____ Taking birth control pills?_____

Do you have or have you ever been informed of having:

	Y	N		Y	N		Y	N
Heart disease. . . .	☐	☐	Asthma	☐	☐	Hepatitis / Jaundice	☐	☐
Heart murmur	☐	☐	Angina	☐	☐	Congenital Heart defects.	☐	☐
Rheumatic fever . . .	☐	☐	Sinus trouble	☐	☐	Abnormal blood pressure. . . .	☐	☐
Stroke	☐	☐	Tuberculosis	☐	☐	Prosthetic valves or joints . . .	☐	☐
Diabetes	☐	☐	Abnormal thyroid	☐	☐	Abnormal bleeding	☐	☐
Epilepsy	☐	☐	Cancer	☐	☐	Mitral valve prolapse	☐	☐
Arthritis	☐	☐	Anemia	☐	☐	Sexually transmitted diseases. . .	☐	☐

Is there any medical condition not listed here that we should be aware of? _____

_____

(Over, please)

Dental History

When was your last dental visit? _____ Were x-rays taken? ……..…… Y ____ N____

Have you ever had any serious problems with previous dental treatment? …… Y ____ N____

Are you missing any teeth that you would be interested in replacing? ……..…… Y ____ N____

Have you ever had prolonged bleeding following extractions? ……..……Y ____ N____

Have you ever been told that you have gum (periodontal) disease? …….. Y_____ N____

Do your gums bleed while brushing or flossing? ……..……..…..Y____ N____

Are any of your teeth sensitive to: _____hot _____ cold _____ sweets _____ chewing / pressure

Are you aware of any problems with your teeth or gums at this time? ……..……Y____ N____

Have you ever experienced any of the following:

Clenching or grinding your teeth ……..….Y____ N ____
Clicking sounds in your jaws ……..…..Y____ N ____
Tired, painful or aching facial/jaw muscles?...Y____ N ____
Difficulty in opening/ closing/chewing...Y___ N___
Frequent headaches or stiff neck…….Y___ N___
Recommendation for a night guard……..Y___ N___

Have you ever been diagnosed with/ tested for **Sleep Apnea**? ……. Y____ N____

If yes, when was your most recent sleep study? _____

Do you suffer from:

Snoring ……..…….…....Y_____ N_____
Interrupted sleep ……..…Y_____ N_____
Dry mouth (while sleeping)...Y_____ N_____
Restless Leg Syndrome ..…. Y_____ N_____
Excessive daytime sleepiness ……..…. Y_____ N _____
Frequent nighttime urination ….…….. Y_____ N_____
Gastric Reflux Disease (GERD) …….. Y_____ N _____
Gasping/choking during sleep ……..….Y_____ N_____

Cosmetic Evaluation

Are you pleased with your smile? …… Y ____ N____

If you could change the appearance of your teeth, what would you change?
color _____ shape _____ size _____ position _____ other _____

Would you be interested in improving your smile with:

Teeth whitening ___ Invisalign (invisible braces) ____ Lumineers (no-drill veneers) ____

*X*_____

Signature of patient or parent if minor *Date*