PATIENT HEALTH INFORMATION

Your answers are for our records only to assist in optimizing your care. Optimal dental care is codependent on an accurate understanding of your systemic health and medications. Many dental procedures and medications interact with your medical status and medications. It is critical we have an accurate medical history.

Patient Name: _____ Today's Date: _____
Last, First MI Preferred Name

Gender: M___F___ Birth Date: _____ Height_____ Weight_____

Primary Physician: _____ Phone: _____

Other Physician(s):_____ Specialty: _____ Phone: _____

_____ Specialty: _____ Phone: _____

- Date of last complete physical examination: _____ Date of last physician visit: _____
- Are you now under the care of a physician? ☐Yes ☐No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past five years? ☐Yes ☐No
  If yes, please explain: _____
- Are you allergic to any medications? ☐Yes ☐No Have you ever had a bad reaction to any medication? ☐Yes ☐No
  If yes, please list: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Women: Are you pregnant? ☐Yes ☐ No Are you currently taking Birth Control Medication? ☐Yes ☐No

Have you ever had any of the following?

Y N Heart Disease
Y N Heart Murmur
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Pacemaker
Y N Defibrillator
Y N Blood Disease
Y N Blood Transfusion
Y N Excessive Bleeding
Y N Stroke

Y N Mental Disorders
Y N Nervous Disorders
Y N Depression
Y N Anxiety

Y N Respiratory Disease
Y N Asthma
Y N Emphysema
Y N Tuberculosis
Y N Sinus Issues
Y N Hay Fever

Y N Artificial Joints
Y N Arthritis
Y N Cortisone Therapy
Y N Rheumatic Fever
Y N Osteoporosis
Y N Osteopenia

Y N Kidney Disease
Y N Frequent Urination
Y N Bladder Difficulty
Y N Prostate Disease
Y N Venereal Disease
Y N HIV / AIDS

Y N Vision Correction
Y N Contact Lens
Y N Glaucoma
Y N Cataract Surgery
Y N Hearing Loss
Y N Hearing Aids
Y N Vertigo

Y N Diabetes
Y N Stomach Problems
Y N Ulcers
Y N Reflux
Y N Liver Disease
Y N Jaundice
Y N Hepatitis

Y N Cancer
Y N Growths
Y N Radiation
Y N Tumors
Y N Chemotherapy

Y N Iodine Allergy
Y N Latex Allergy

(*OVER PLEASE)*

ARE YOU REQUIRED TO TAKE ANTIBIOTICS PRIOR TO DENTAL CARE FOR A HEART MURMUR, REPLACEMENT HEART VALVE, OR ARTIFICIAL JOINT? Y N

MEDICATION HISTORY

Medication	Dosage	How Often	Reason

Do you drink alcoholic beverages? ☐Yes ☐No If yes, amount…per day____per week____Very infrequently___

Do you smoke? ☐Yes ☐No Have you smoked, but quit? ☐Yes ☐No
If yes, length of time that you smoked and if you quit, when? _____

Have you been under more than average nervous tension lately? ☐Yes ☐No

Do you regularly eat a well-balanced diet including fruits and vegetables? ☐Yes ☐No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my medical health, I will inform the doctors at the next appointment without fail. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

_____ Date: _____
Signature of patient, parent or guardian

(OFFICE USE)

SUMMARY

MEDICAL CONDITIONS RELEVANT TO DENTAL CARE:

MEDICATIONS RELEVANT TO DENTAL CARE:

PRECAUTIONS AND COMMENTS:

ATTENDANT SIGNATURE:-_____ DATE: _____

PATIENT DENTAL INFORMATION

Patient Name_____ Today's Date_____-
Last First MI Preferred Name

Primary Dentist_____ Did They Refer You?_____

Other Dental Specialist(s)_____ Did They Refer You? _____

_____ _____

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

Have you had any other consultations regarding the reason for this referral? _____

WHAT IS YOUR MAIN DENTAL CONCERN AT THIS TIME? _____

_____

Do you have a good understanding of your present dental status or the reason for being referred for evaluation? _____

Are you presently, or have you recently been experiencing pain in your mouth or face? _____ Yes _____ No. If yes, please explain: _____

Are you worried about receiving dental treatment? ____Yes ____No

Have you ever had any complications following dental treatment? ____ Yes ____ No
If yes, please explain: _____

Have you ever reacted adversely to a local anesthetic? ____Yes ____No

Are you dissatisfied with the appearance of your teeth? ____Yes ____No

Would it upset you to lose your remaining teeth? ____Yes ____No

Does anyone in your family wear dentures or have periodontal disease? ____Yes ____No If yes, who?_____

Have you ever had any of the following?

Y N **Periodontal treatment**
Y N Bite Splint
Y N Occlusal adjustment
Y N Orthodontic treatment
Y N Root canal treatment
Y N Dental Implant Care
Y N Dental bridges
Y N Partial dentures
Y N Complete dentures
Y N Bleeding gums
Y N Oral surgery

Y N Swollen gums
Y N Sore gums
Y N Loose teeth
Y N Shifting teeth

Y N Bad tastes
Y N Bad breath
Y N Dry mouth
Y N Sensitive teeth (hot/cold)
Y N Difficulty in chewing

Y N Injury to face or jaw
Y N Jaw joint pain
Y N Jaw joint clicking
Y N Frequent, severe headaches

Y N Jaw clenching
Y N Teeth grinding
Y N Chewing habits (gum, nails)
Y N Frequent cold sores
Y N Frequent canker sores

(OVER PLEASE)

ORAL HYGIENE

How often do you brush your teeth? _____ When do you brush? _____

What texture is your toothbrush? _____ Do you use mouthwash? _____

How often do you floss? _____Do you use anything else to clean your teeth? _____

Have I treated any of your family or friends? ☐Yes ☐No If yes, who?_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my dental health, I will inform the doctors at the next appointment without fail. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

_____ Date: _____
Signature of patient, parent or guardian

(OFFICE USE)

SUMMARY

REFERRAL HISTORY:

PATIENT CONCERNS:

INFORMATION RELEVANT TO PRESENT CONDITION:

COMMENTS:

ATTENDANT SIGNATURE:-_____ DATE: _____