

Patient Health Record

Are you required to take antibiotics before dental treatment? Yes ___ No ___

Patient Name _____ Date of Birth _____

Occupation _____ General Health: Excellent Good Fair Poor

Name and address of Primary Care Physician _____

Date of Last Physical _____

Current Medications _____

Have you ever been treated for the following: (Please check all that apply)

Jaundice _____ Heart Disease _____ Anemia _____ Ulcers _____ Cough _____
Hepatitis _____ Sinus Trouble _____ Arthritis _____ Asthma _____ Glaucoma _____
Diabetes _____ Heart Murmur _____ Epilepsy _____ Stroke _____
Rheumatic Fever _____ Hay Fever _____ Congenital Heart Lesions _____ Tuberculosis or Lung Disease _____
Abnormal Blood Pressure _____ Artificial Joint Replacement _____

Have you ever been treated (other than diagnostic) with x-ray? Yes ___ No ___

Are you allergic to: Penicillin Codeine Local Injected Anesthetics Latex Peanut Products

Are you pregnant? _____ If so, how far along _____

Reason for visit _____ Date of Last Dental visit _____

Have you ever had a serious problem associated with previous dental treatment _____

If so, please explain. _____

How often do you brush your teeth? _____ Floss _____

What texture brush do you use? Soft Medium Hard Nylon Natural

Do your gums bleed while brushing? Yes No Flossing? Yes No

Do you avoid brushing any part of your mouth because of pain? Yes No

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids-soup or coffee? _____ Cold foods-ice cream, fruit? _____

Sweets-candy, desserts? _____ Sours-lemons, grapefruit? _____

Do you chew food on only one side of your mouth? _____ Explain _____

Do you have pain or noise in your jaw joint? _____ Explain _____

Do your gums feel tender or swollen? _____

Do you clench or grind your jaws while sleeping or during the day? _____

Does your jaw ever feel tired? _____ Do you wear dentures? _____

Do you usually have many cavities? _____ Do you lose or break fillings? _____

Do you gag easily? _____ Are you satisfied with the appearance of your teeth? _____

Are you familiar with the term "preventive dentistry"? _____

Patient Signature

Date

Comments: _____
