

PATIENT HEALTH INFORMATION

Name _____ Date of Birth _____

Dental Health

Reason for this visit _____ Date of last visit _____

Date of last x-rays? _____ May we request these x-rays from your previous dentist? _____

Name and address of your previous dentist _____

Have you had any problems associated with past dental care? _____

How would you rate your present dental health? Good _____ Fair _____ Poor _____

Do you use floss daily? _____ Do you have pain in any of your teeth or jaw? _____

Do your gums bleed easily? _____ Do you clench or grind your teeth or jaw? _____

MEDICAL HEALTH

1. Has there been any change in your general health within the past year? YES _____ NO _____

Please explain: _____

2. Are you under the care of a physician at present? YES _____ NO _____

Please explain: _____

3. What medications are you currently taking? _____

4. Please list any allergies or medications you are allergic to: _____

5. Have you ever had excessive bleeding requiring special treatment? YES _____ NO _____

Please explain: _____

6. When was your last physical exam? _____ Physician's Name _____

List any problems found: _____

7. Women: Are you pregnant now? YES _____ NO _____ Due Date _____

8. Have you ever been treated for or been told by a doctor that you have or had any of the following conditions:

	YES	NO		YES	NO
Mitral Valve Prolapse	_____	_____	Cancer	_____	_____
Congenital Heart Problems	_____	_____	Tuberculosis	_____	_____
Heart Murmur	_____	_____	Venereal Disease	_____	_____
Heart Trouble/Heart Surgery	_____	_____	Severe Headaches	_____	_____
Angina	_____	_____	Hepatitis (Jaundice)	_____	_____
Cardiac Pacemaker	_____	_____	Epilepsy or seizures	_____	_____
Low Blood Pressure	_____	_____	Psychiatric Treatment	_____	_____
High Blood Pressure	_____	_____	Diabetes or Hypoglycemia	_____	_____
Stroke	_____	_____	AIDS/HIV	_____	_____
Leukemia	_____	_____	Chronic Cough	_____	_____
Anemia	_____	_____	Herpes or Fever Blisters	_____	_____
Asthma	_____	_____	Sinus Trouble (Recurrent)	_____	_____
Hay Fever or Allergies	_____	_____	Canker Sores (Recurrent)	_____	_____
Rheumatic Fever	_____	_____	Joint Surgery or Joint Replacement	_____	_____
Arthritis or Rheumatism	_____	_____	Date of Replacement Surgery _____		
Kidney Disease	_____	_____			

9. Is there any information about your health that has not been covered above? _____

To the best of my knowledge, this information provided is true and correct.