Patient Health Record

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

DATE

NAME (LAST) (FIRST) (MIDDLE)

ADRESS CITY STATE ZIP CODE

PHONE BUSINESS ADDRESS PHONE

DATE OF BIRTH SEX HEIGHT WEIGHT OCCUPATION

REFERRED BY PURPOSE OF THIS APPOINTMENT MOST CONVENIENT APPOINTMENT TIME

MARITAL STATUS (CHECK) SINGLE MARRIED WIDOWED DIVORCED

SPOUSES NAME

TYPE OF DENTAL INSURANCE (IF APPLICABLE) SOCIAL SECURITY NO.

MEDICAL HEALTH

General health (please check) : EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name and address of physician _____

_____

Last Complete physical? _____

Are you taking any medication now? Yes ☐ No ☐ For what purpose? _____

List Medication _____

Have you ever been treated for:

Heart disease	Yes ☐	No ☐	Heart murmur	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Asthma or hay fever	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Tuberculosis or lung disease	Yes ☐	No ☐	Cough	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Arthristis	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Congenital heart lesions	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
Aids	Yes ☐	No ☐	Venereal Disease	Yes ☐	No ☐

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

Are you allergic to: Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐ _____

Are you subjesct to prolonged bleeding? ..... Yes ☐ No ☐

Are you subject to fainting spells? ..... Yes ☐ No ☐

Do you have excessive urination and/or thirst? ..... Yes ☐ No ☐

(women)

Are you pregnant? ..... Yes ☐ No ☐ How long? _____