PERSONAL HEALTH RECORD

Updated

Date _____ Initials _____

Date _____ Initials _____

Date _____ Initials _____

Patient's Name _____ Date _____
(LAST) (FIRST) (INITIAL)

Patient's Email _____ Home Phone _____ Bus. Phone _____

Address _____ Cell Phone _____

Date of Birth _____ Social Security # _____ Sex _____ Height _____ Weight _____

Occupation _____ Marital Status _____ Spouse's Name _____

Emergency Contact _____ Phone _____

Name and Address of Physician _____

Whom may we thank for referring you to us? _____

MEDICAL HEALTH

Has there been any change in your general health within the past year?_____

My last physical examination was on _____

Are you presently under the care of a physician?_____

If so, what is the condition being treated?_____

Have you ever had a serious illness or major surgery?_____

Have you been hospitalized for treatment within the past 5 years?_____

If female; Are you taking hormones or birth control?_____Are you pregnant or nursing?_____

Have you ever had a blood test for hepatitis?_____Were you vaccinated?_____

Have you ever had cankers or cold sores on your lips, tongue, gums or body?_____

Are you presently taking any drugs, medications, or pills? If so, list?_____

_____

These drugs are being taken for what condition(s)?_____

Are you allergic to? ❑ Penicillin ❑ Other antibiotics ❑ Codeine ❑ Asprin ❑ Local Anesthetics ❑ Latex ❑ Other_____

Have you had or do you now have:	Yes	No
AIDS/HIV Positive	❑	❑
Abnormal Blood Pressure	❑	❑
Allergies (include hives, skin rash)	❑	❑
Anemia	❑	❑
Angina	❑	❑
Arthritis	❑	❑
Artificial Heart Valves	❑	❑
Artificial Joints	❑	❑
Autoimmune disease (rheumatoid, arthritis, lupus, scleroderma, etc.)	❑	❑
Asthma (or other lung disease)	❑	❑
Cancer	❑	❑
Chemotherapy	❑	❑
Congenital Heart Defects	❑	❑
Diabetes	❑	❑
Digestive Disorder (Celiac Disease, Gastric Reflux)	❑	❑
Drug Dependency and/or in Recovery	❑	❑
Epilepsy	❑	❑
Fainting	❑	❑
Glaucoma	❑	❑
Head or Neck Injuries	❑	❑

	Yes	No
Heart Disease	❑	❑
Heart Murmur (mitral valve prolapse)	❑	❑
Hepatitis (type _____)	❑	❑
Herpes	❑	❑
Insomnia	❑	❑
Kidney Disease	❑	❑
Liver Disease/Jaundice	❑	❑
Metal Allergy (ex. a rash from jewelry)	❑	❑
Organ Transplant	❑	❑
Osteoporosis/Osteopenia (i.e. taking bisphosphonates)	❑	❑
Pacemaker	❑	❑
Prolonged Bleeding	❑	❑
Prolonged Cough	❑	❑
Psychiatric Treatment	❑	❑
Radiation Therapy (for growth or tumor)	❑	❑
Sickle Cell Anemia	❑	❑
STI, STD, HPV	❑	❑
Stroke	❑	❑
Thyroid Disease	❑	❑
Tuberculosis	❑	❑
Ulcers	❑	❑

Have you had any disease, condition, or problem not previously listed? _____

_____

(*OVER*)

DENTAL HEALTH

Are you having any dental problems that require immediate attention? _____
How would you describe your dental health? Excellent _____ Good _____ Fair _____ Poor _____
How long since your last dental appointment? _____
How often did you see your dentist? _____
Do you think your teeth are affecting your general health? _____
Do you have any pain, lumps, or swelling of the face or jaws? _____
Have you ever had any injury to your face or jaws? _____
Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____
Do you have a bad taste or mouth odor? _____
How often do you brush your teeth? _____ Floss?_____ Additional cleaning aids?_____
Do you frequently consume sweet foods or drinks between meals? _____
Do you use tobacco? _____ How often do you use alcohol? Never _____ Seldom _____ Weekly _____ Daily _____
Do your gums bleed after brushing your teeth? _____
Do your gums feel tender or swollen? _____
Have you had periodontal (gum) treatment? _____ When?_____
Do you have any loose teeth? _____ Cracked or broken teeth?_____
Do you notice your teeth wearing away? _____ Does food wedge between your teeth anywhere?_____
Do you have any teeth which seem to be shifting position? _____
Do you clench or grind your teeth? (including while you're asleep) _____
Do your jaws ever feel tired or ache? _____ Do your jaws ever click or pop?_____
Can you chew on both sides of your mouth? _____ Comfortably?_____
Do you have frequent headaches? _____ Earaches?_____
Have you ever had orthodontic treatment (braces)? _____ When? _____
Have you had many cavities in the past? _____
Do you have any missing teeth? _____ Have they been replaced? _____
If so, how? Fixed Bridge _____ Removable partial _____ Full denture _____ Dental implant _____
Are you comfortable with the replacement? _____
Do you ever have a problem with your mouth being too dry? _____
Do you have a snoring problem or trouble getting a good night's rest? _____
How do you feel about the appearance of your smile? _____
Have you ever had any cosmetic dentistry done to improve your appearance? _____
If so, are you pleased with the results? _____ Please comment: _____
_____
Have you ever had an unpleasant dental experience? _____
In general, do dental treatments cause you much concern or worry, or make you tense? _____
Comments: _____
_____
Is there anything specific we can do to make your visits more comfortable? _____
_____
_____
Please add anything you feel is important: _____
_____
_____
_____
_____
_____
Signature _____