# HEALTH RECORD

**Information about your general health is important for us to know in planning your dental treatment. This information is, of course, confidential.**

| Name | Date of Birth | File Number |
|---|---|---|
| | | |

## Dental History

Name and address of former dentist

When was your last check-up?

Have you had a complete series of x-rays taken? When?

Are you aware of a dental problem? If yes, explain.

What do you feel is the present condition of your mouth?

Are you interested in preventing dental problems by having regular dental examinations and care?

Please ☑ any of the following that apply to you (now or in the past):

- ☐ Gums bleed
- ☐ Gum disease
- ☐ Food collects
- ☐ Grinding or clenching
- ☐ Smoker
- ☐ Jaw joint noise
- ☐ Locked jaw
- ☐ Unpleasant taste
- ☐ Mouth sores
- ☐ Bite is off
- ☐ Wisdom teeth removed
- ☐ Teeth sensitive to sweets
- ☐ Teeth sensitive to cold
- ☐ Teeth sensitive to heat
- ☐ Teeth sensitive to pressure
- ☐ _____

How often do you brush your teeth?

How often do you floss your teeth?

## Medical History

Name and address of physician

Are you now under the care of a physician? If yes, for what reason?

Have you ever had any serious illness or accident? If yes, please explain.

List all medications or drugs and dosages that you are taking.

_____

_____

_____

(Women) Are you pregnant? If yes, how long?

## Medical History (continued)

Please ☑ any of the following that apply to you (now or in the past):

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Congenital Heart Defect
- ☐ Abnormal Blood Pressure
- ☐ Ulcers
- ☐ Tuberculosis, Lung Disease
- ☐ Diabetes
- ☐ Excessive Urination, Thirst
- ☐ Eating Disorders
- ☐ Epilepsy, Convulsions
- ☐ Anemia
- ☐ Thyroid Problem
- ☐ Chemical Dependency
- ☐ IV Drug Abuse
- ☐ Abnormal Bleeding
- ☐ Fainting Spells
- ☐ Hepatitis
- ☐ HIV Positive/AIDS
- ☐ Jaundice
- ☐ Asthma, Hay Fever
- ☐ Sinus Problems
- ☐ Tumors
- ☐ Stroke
- ☐ Glaucoma
- ☐ Radiation Therapy
- ☐ Mental Health Care
- ☐ Prosthetic Implant/Pacemaker
- ☐ Artificial Hip/Knee
- ☐ Venereal Disease
- ☐ Arthritis
- ☐ Tobacco Use
- ☐ Oral Contraceptives

**Are you allergic to:**

- ☐ Penicillin
- ☐ Codeine
- ☐ Local anesthetic
- ☐ Other _____

Patient Signature _____ Date _____

Recorded By _____ D.D.S. Signature _____

## Medical Updates (Staff use) Note changes, date and sign.

| | | |
|---|---|---|
| Date ☐ no change ☐ see notes | Date ☐ no change ☐ see notes | Date ☐ no change ☐ see notes |
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