

PATIENT HEALTH RECORD

Date _____

Name _____ Email _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____

Date of Birth _____ Social Security _____

Occupation _____ Employer _____ Single _____ Married _____

Emergency Contact _____ Phone _____

Who may we thank for referring you to us? _____

Preferred Contact Number _____

MEDICAL HEALTH

Name and address of physician _____

Have you been under a physician's care during the past two years? _____ For _____

Have you been treated in a hospital in the past two years? _____ For _____

Have you ever had major surgery? _____ For _____

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

Are you now taking or have you taken any prescription drugs during the past year? _____

Please list the medications you are taking, including vitamins, herbs & OTC _____

If female: Are you taking hormones or birth control? _____ Are you pregnant/nursing? _____

Are you allergic to: Penicillin Codeine Local Anesthetics Other _____

Have you or do you now have:

	yes	no		yes	no
Abnormal Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High			Type _____		
<input type="checkbox"/> Low			Date _____		
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart lesions.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Polio.....	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Drug dependency.....	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged cough.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Type _____					
Date _____					

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

Have you ever been told that you need to take antibiotics prior to your dental treatment? _____