PLANNED HEALTH CARE RECORD

It is important to tell dental personnel involved in your treatment about the general state of your health. This information is, of course, confidential.

Name ________________________________ Date of Birth ____________

DENTAL HISTORY

1. How did you find out about our office? ____________________________
2. Former dentist ____
3. How long since your last thorough dental examination? ______________
   What was done at this time? ____________________________
   X-rays taken? ___ Yes ___No
   Why did you leave the practice? ____________________________
   Did you make regular visits to the dentist before then? ___ Yes ___ No
4. Are you aware of a dental problem? ___Yes ___No Explain ______________
   ____
5. What do you feel is the present condition of your mouth? ______________
   ____
6. Do your gums bleed? ___Yes ___No
7. Have you ever been told you have gum disease? ___Yes ___No
8. Does food chronically collect between your teeth? ___Yes ___No
9. Are your teeth acutely sensitive to: ___ Sweet ___ Cold ___ Heat ___ Pressure ___ No
10. How often do you brush your teeth? ____________________________
11. How often do you floss your teeth? ____________________________
12. What concerns you most about dentistry? Time? Fear? Money? ____________
13. Do you snack frequently on sweets or drink pop? ______________________
14. What are your expectations for your teeth? __________________________
15. Do you clench or grind your teeth or have any jaw joint pain? ____________
16. Are you happy with the appearance of your smile? ___ Yes ___ No Explain ______
    ____

MEDICAL HISTORY

1. Name and address of physician ____________________________________
2. When was your last physical examination? ____________________________
3. Are you now under the care of a physician? ___ Yes ___ No
   If yes, for what reason? ____________________________
4. Are you presently taking any medications/drugs/pills? ___ Yes ___ No
   Please list: ____
   ____
   ____
   ____

(OVER PLEASE)

5. (Women) Are you pregnant? ___Yes ___ No If yes, how long? ________________

6. Are you allergic to: __ Penicillin __ Codeine __ Local Anesthetic __ None __ Other

7. Do you have, or have you ever had:

Heart trouble -	__Yes __No	Arthritis-	__Yes __No
Heart murmur-	__Yes __No	Excessive or prolonged bleeding-	__Yes __No
Heart pacemaker-	__Yes __No	Fainting spell-	__Yes __No
Heart surgery-	__Yes __No	Jaundice-	__Yes __No
Rheumatic Fever-	__Yes __No	Hepatitis-Type:__________	__Yes __No
Congenital heart defects-	__Yes __No	Asthma-	__Yes __No
Abnormal blood pressure-	__Yes __No	Sinus Trouble-	__Yes __No
Ulcers-	__Yes __No	Cancer-	__Yes __No
Tuberculosis or lung disease-	__Yes __No	Chemotherapy/radiation-	__Yes __No
Diabetes-	__Yes __No	Stroke-	__Yes __No
Epilepsy-	__Yes __No	Glaucoma-	__Yes __No
Anemia-	__Yes __No	Psychiatric care	__Yes __No
Thyroid problem-	__Yes __No	Prosthetic implant	__Yes __No
Chemical dependency-	__Yes __No	Venereal disease	__Yes __No
		HIV positive/AIDS-	__Yes __No

8. Have you had any other serious illness, hospitalization or accident? __Yes __No

If yes, please explain ____

____

____

Patient Signature:________________________________ Date:______________

(PARENT OR GUARDIAN IF MINOR)

UPDATED:______________ BY:__________
Current Medications____________________
Current Conditions____________________
Physician____________________
Patient Signature____________________

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Current Medications____________________
Current Conditions____________________
Physician____________________
Patient Signature____________________

UPDATED:______________ BY:__________
Medical Conditions:____________________
Medications:____________________
Current Physician:____________________
Patient Signature:____________________

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