

# Patient Health Record

Hagerstown Smiles Dental Care  
1115 Mt. Aetna Rd.  
Hagerstown, MD 21740

The following information is requested to assist us in providing proper dental service. Please answer the questions to the best of your ability. If you have questions, please don't hesitate to ask us. All information will help us to give you the most consideration of your time and feelings, and will help us to attain our goal of excellence in care. All information is, of course, confidential. Thank you for your cooperation.

DATE \_\_\_\_\_ REASON FOR VISIT \_\_\_\_\_

NAME (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_ EMAIL \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PLACE OF WORK \_\_\_\_\_ OCCUPATION \_\_\_\_\_

DENTAL INSURANCE (if any) \_\_\_\_\_

MARITAL STATUS single married widowed divorced WHO RECOMMENDED OUR OFFICE? \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ SPOUSE'S OCCUPATION \_\_\_\_\_

EMERGENCY CONTACT: NAME \_\_\_\_\_ RELATION \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK \_\_\_\_\_

## HEALTH HISTORY

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR DENTAL HEALTH: EXCELLENT GOOD FAIR POOR

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

NAME AND ADDRESS OF YOUR PHYSICIAN: \_\_\_\_\_

LAST COMPLETE PHYSICAL: \_\_\_\_\_

Please list ALL medicines (both prescription and non-prescription) that you take regularly: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DOES YOUR DOCTOR REQUIRE YOU TO TAKE SPECIAL MEDICATION BEFORE DENTAL WORK? YES NO

ARE YOU BEING TREATED WITH IMMUNOSUPPRESSIVE DRUGS/STEROIDS YES NO

ARE YOU UNDER THE REGULAR CARE OF A PHYSICIAN? YES NO

IF YES, FOR WHAT \_\_\_\_\_

HAVE YOU EVER BEEN HOSPITALIZED? IF SO, PLEASE GIVE NAME OF HOSPITAL, REASON AND DATES.

\_\_\_\_\_  
\_\_\_\_\_

<b>DO YOU USE TOBACCO PRODUCTS?</b> YES NO	
CIGARETTES PIPE SMOKELESS TOBACCO	<b>WOMEN:</b>
IF YES...HOW MUCH/MANY PER DAY:	<b>-ARE YOU PREGNANT?</b> YES NO
<b>DO YOU CONSUME ALCOHOL DAILY:</b> YES NO	IF YES, HOW FAR?
<b>HAVE YOU HAD ANY RECENT WEGHT CHANGE?</b> YES NO	<b>-ARE YOU NURSING?</b> YES NO

ARE YOU **ALLERGIC** TO: ANTIBIOTICS CODEINE LOCAL ANESTHETICS/NOVOCAINE LATEX SULFA DRUGS  
ASPIRIN METAL OTHER

IF OTHER PLEASE LIST: \_\_\_\_\_

## MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE IF YES)

ARTIFICIAL JOINTS	THYROID PROBLEMS	HORMONAL PROBLEMS
ARTIFICIAL VALVES	BRUISE EASILY	TUBERCULOSIS
ORGAN TRANSPLANT	BLOOD TRANSFUSION	LUNG DISEASE
CHEST PAINS	JAUNDICE	CANCER
MITRAL VALVE PROLAPSE	PERSISTENT DIARRHEA	LEUKEMIA
HEART DISEASE	ULCERS	ENLARGED LYMPH NODES
RHEUMATIC FEVER	COLITIS	BLUISH/REDDISH LESIONS
CONGENITAL HEART DEFECTS	EXCESSIVE URINATION	OSTEOPOROSIS/OSTEOPENIA
HEART MURMUR	EXCESSIVE THIRST	GLAUCOMA
PACEMAKER	EPILEPSY/SEIZURES	ASTHMA OR HAY FEVER
HYPERTENSION	PSYCHIATRIC PROBLEMS	ALLERGIES OR HIVES
HIGH/LOW BLOOD PRESSURE	SICKLE CELL DISEASE	SINUS TROUBLE
HEPATITIS	PERSISTENT COUGH	ARTHRITIS
KIDNEY PROBLEMS	UNEXPLAINED FEVERS	BLEEDING PROBLEMS
DIALYSIS	PROLONGED SORE THROAT	A.I.D.S. OR H.I.V.
STROKE	NIGHT SWEATS	SEXUALLY TRANSMITTED DISEASES
DIABETES: TYPE 1 OR TYPE 2	FATIGUE	(GONORRHEA, SYPHILIS, HERPES)

## DENTAL HEALTH

WOULD YOU RATHER BE IN THE DENTIST'S OFFICE OR AT DISNEY WORLD? \_\_\_\_\_

WHEN WAS YOUR LAST DENTAL VISIT? \_\_\_\_\_

WHY DID YOU LEAVE YOUR LAST DENTIST? \_\_\_\_\_

HAVE YOU EVER HAD ANY SERIOUS PROBLEMS ASSOCIATED WITH DENTAL TREATMENT?----- YES NO

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

DO YOU HAVE A HISTORY OF COLD SORES, FEVER BLISTERS OR CANKER SORES----- YES NO

HOW OFTEN DO YOU BRUSH YOUR TEETH? \_\_\_\_\_ HOW OFTEN DO YOU FLOSS? \_\_\_\_\_

DO YOU EXPERIENCE DRY MOUTH?-----YES NO DO YOU GAG EASILY?----- YES NO

DO YOUR GUMS BLEED WHEN YOU BRUSH OR FLOSS THEM?----- YES NO

DO YOUR GUMS FEEL TENDER OR SWOLLEN?-----YES NO

ARE ANY OF YOUR TEETH SENSITIVE TO AIR, COLD, SWEETS, HOT, OR CHEWING?----- YES NO

WHAT TYPE OF BRUSH DO YOU USE? SOFT MEDIUM HARD ELECTRIC

DO YOU HAVE PERSISTENT BAD BREATH (HALITOSIS)?----- YES NO

DOES FOOD CATCH BETWEEN YOUR TEETH?----- YES NO

DO YOU CLENCH OR GRIND YOUR TEETH WHILE SLEEPING OR DURING THE DAY?----- YES NO

DO YOUR FACIAL MUSCLES EVER FEEL TIRED?----- YES NO

HAVE YOU BEEN DIAGNOSED WITH MIGRAINE HEADACHES?----- YES NO

DO YOU WEAR OR HAVE YOU WORN DENTURES?----- YES NO

ARE YOU NERVOUS ABOUT YOUR DENTAL TREATMENT?----- YES NO

HAVE YOU EVER BEEN PRESCRIBED ANTI ANXIETY MEDICINE BEFORE DENTAL APPOINTMENTS?- YES NO

DO YOU LOVE YOUR SMILE?-----YES NO

IF NO, WHAT ABOUT IT WOULD YOU CHANGE? \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL MEDICAL OR DENTAL CONDITIONS/PROBLEMS NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT?----- YES NO

I DO HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

DATE

DOCTOR'S NOTES AND HEALTH HISTORY UPDATES

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