PATIENT HEALTH RECORD AND PHYSICAL EVALUATION

Please be accurate. It will help us provide you a safe and comprehensive dental treatment.

	Yes	No	
1.	☐	☐	Are you having pain and discomfort at this time?.....
2.	☐	☐	Do you feel very nervous about having dental treatment?.....
3.	☐	☐	Have you ever had a bad experience in a dental office?.....
4.	☐	☐	Have you been a patient in a hospital during the past two years?.....
5.	☐	☐	Have you been under the care of medical doctor during the past two years?.....
6.	☐	☐	Have you taken any medication or drugs during the past two years?.....
7.	☐	☐	Have you ever had any excessive bleeding requiring special treatment?.....
8.	☐	☐	Have your medical doctor ever said you have a cancer or tumor?.....
9.	☐	☐	Have you lost or gained more than 10 pounds in the past year?.....
10.	☐	☐	Have you ever taken Fen-Phen?.....
11.	☐	☐	Are you on a special diet?.....
12.	☐	☐	Do you ever wake up from sleep due to shortness of breath?.....
13.	☐	☐	When you walk up stairs or take a walk, do you ever had to stop because of pain in your chest, or shortness of breath, or because you are very tired?.....
14.	☐	☐	Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by Penicillin, Aspirin, Codeine, Vicodin, Latex, or any drug or medicine?.....

Do you have or have you had any of the following, indicate with a (X)

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Failure	☐	☐	Emphysema	☐	☐	A I D S
☐	☐	Heart Disease or Attack	☐	☐	Chronic Bronchitis	☐	☐	HIV+
☐	☐	Angina Pectoris	☐	☐	Asthma	☐	☐	Yellow Jaundice
☐	☐	High Blood Pressure	☐	☐	Heart Murmur	☐	☐	Hepatitis A (Infection)
☐	☐	Rheumatic fever	☐	☐	Tuberculosis (TB)	☐	☐	Hepatitis B (Serum)
☐	☐	Artificial Heart Valve	☐	☐	Sinus Trouble	☐	☐	Drug or Alcohol Abuse
☐	☐	Heart pacemaker	☐	☐	Hay Fever or Allergies	☐	☐	Hemophilia
☐	☐	Heart Surgery	☐	☐	Allergy to Latex	☐	☐	Venereal Disease
☐	☐	Artificial Joints	☐	☐	Diabetes	☐	☐	Cold Sore
☐	☐	Anemia	☐	☐	Thyroid Disease	☐	☐	Epilepsy or Seizures
☐	☐	Stroke	☐	☐	X-Ray or Cobalt Treatment	☐	☐	Fainting or Dizzy Spells
☐	☐	Kidney Trouble	☐	☐	Chemotherapy (Cancer, Leukemia)	☐	☐	Nervousness
☐	☐	Ulcers	☐	☐	Arthritis	☐	☐	Psychiatric Treatment
☐	☐	Glaucoma	☐	☐	Rheumatism	☐	☐	Sickle cell Disease
☐	☐	Pain in Jaw Joint	☐	☐	Cortisone Medicine	☐	☐	Bruise Easily

Do you have any disease, condition or problem not listed?.....

Name of your medical doctor:.....Phone #:.....

Woman:

Are you pregnant now?.....Do you anticipate becoming pregnant?.....Are you practicing birth control?.....Are you nursing?.....

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Patient Name:..... **Signature:** ..... **date:**.....

Physical Evaluation Results:

ASA: I II III IV

BP:_____

Pulse:_____

Resp:_____

Temp:_____

_____ Doctor Signature

_____ Assistant Signature

Medical History Update