PATIENT HEALTH HISTORY

Please Read

Will you kindly answer the following questions. In this office, we are very much interested in helping you with your program of health and well being. We feel that this interest in your appearance, comfort, and ability to chew, digest and enjoy your food is one of the reasons why you are here.

In order to prevent or control disease to maintain healthy teeth, gums and bone, it is necessary as a part of any complete examination, to know about your general health and feelings. This information is invaluable in determining accurate treatment suggestions, which will be discussed with you in detail. This information, of course, will be held confidential.

Referred To Office By _____

ADULT

CHILD

PLEASE PRINT **1**

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____

Cell # _____

E-mail _____

Business Address _____

City _____ State _____ Zip _____

Bus. Phone # _____ Birthdate _____

Married _____ Single _____ Divorced _____ Widowed _____

Occupation _____

SS# _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____

Birthdate _____ Age _____ Grade _____

School _____

*** If your child's name and address are not the same as yours, please fill in the box on top also.**

INSURANCE **2**

Primary Carrier

Insurance Co. _____

Ins. Tel. # _____

Employer _____

Union or Local # _____

Group # _____

Insured SS # _____

Secondary Carrier

Insurance Co. _____

Ins. Tel. # _____

Employer _____

Union or Local # _____

Group # _____

Social Security # _____

JAY PISKIN, D.D.S.

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MEDICAL HISTORY:

1. GENERAL HEALTH (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐
2. NAME AND ADDRESS OF PHYSICIAN _____

_____ (PHONE #)

3. LAST COMPLETE PHYSICAL? _____

	YES	NO
4. ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?	☐	☐
IF YES, PLEASE EXPLAIN _____		
5. HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE LAST 5 YEARS?	☐	☐
IF YES, PLEASE EXPLAIN _____		
6. ARE YOU TAKING ANY MEDICATION NOW? (PILLS, VITAMINS, SYRUP, ETC.)	☐	☐
PLEASE LIST _____		

7. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS OR DISEASES?

(CHECK BOX)	YES	NO		YES	NO
HEART DISEASE OR HEART ATTACK	☐	☐	JAUNDICE, HEPATITIS OR LIVER DISEASE	☐	☐
RHEUMATIC FEVER	☐	☐	ASTHMA OR HAY FEVER	☐	☐
HEART MURMUR OR MITRAL VALVE PROLAPSE	☐	☐	SINUS TROUBLE	☐	☐
ABNORMAL BLOOD PRESSURE	☐	☐	HIV OR AIDS	☐	☐
ULCERS	☐	☐	ARTHRITIS OR SORE JOINTS	☐	☐
TUBERCULOSIS OR LUNG DISEASE	☐	☐	STROKE	☐	☐
DIABETES OR ANEMIA	☐	☐	GLAUCOMA	☐	☐
CONGENITAL HEART LESIONS	☐	☐	VENEREAL DISEASE (SYPHILIS OR GONORRHEA)	☐	☐
HEART VALVE OR JOINT REPLACEMENT	☐	☐	CANCER, TUMORS OR GROWTHS	☐	☐
OTHER _____	☐	☐			

	YES	NO
8. ARE YOU ALLERGIC TO ANY DRUGS OR MEDICATION SUCH AS PENICILLIN, CODEINE, ASPIRIN OR LOCAL INJECTED ANESTHETICS?	☐	☐
IF YES, WHAT? _____		
9. ANY ALLERGIES TO LATEX?	☐	☐
10. ARE YOU TAKING BLOOD THINNERS OR SUBJECT TO PROLONGED BLEEDING?	☐	☐
11. DO YOU HAVE EXCESSIVE URINATION AND/OR THIRST?	☐	☐
12. DO YOU USE TOBACCO?	☐	☐

WOMEN:

	YES	NO
1. ARE YOU PREGNANT?	☐	☐

DENTAL HISTORY:

	YES	NO
1. ARE YOU AWARE OF ANY DENTAL PROBLEMS AT THIS TIME?	☐	☐
IF YES, PLEASE EXPLAIN _____		
2. WHEN WAS YOUR LAST DENTAL VISIT? _____	☐	☐
3. ARE YOU SEEN IN A DENTAL OFFICE ON A REGULAR BASIS?	☐	☐
IF YES, PLEASE EXPLAIN _____		
4. WHEN WAS YOUR LAST FULL MOUTH SERIES OF X-RAYS TAKEN? _____		
5. WHEN WAS YOUR LAST DENTAL CLEANING? _____		
6. DO YOUR GUMS BLEED WHILE BRUSHING?	☐	☐
7. DO YOU HAVE A BAD TASTE OR ODOR IN YOUR MOUTH OR BEEN TOLD YOU HAVE BAD BREATH?..	☐	☐
8. HOW OFTEN DO YOU BRUSH YOUR TEETH?		
9. DO YOU USE ANY OF THE FOLLOWING?		
TOOTHBRUSH ☐ HARD ☐ MEDIUM ☐ SOFT ☐ FLOSS ☐ TOOTHPICKS ☐ OTHER _____		
10. DO YOU CHEW ON ONLY ONE SIDE OF YOUR MOUTH?	☐	☐
IF YES, PLEASE EXPLAIN _____		
11. ARE YOU FAMILIAR WITH THE TERM, "PREVENTIVE DENTISTRY"?	☐	☐
12. ARE YOU PLEASED WITH THE APPEARANCE OF YOUR TEETH?	☐	☐
IF NOT, WHY? _____		
13. DOES THE NOISE OF HIGH SPEED EQUIPMENT BOTHER YOU?	☐	☐
14. INTERESTS AND HOBBIES _____		

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PROCEEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR OF DENTISTRY AT THE NEXT APPOINTMENT WITHOUT FAIL.

DATE _____ SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ SIGNATURE OF DENTIST _____