

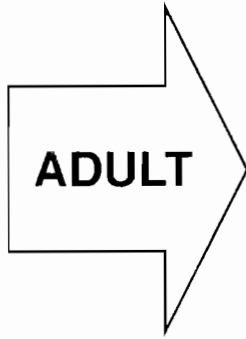
# PATIENT HEALTH HISTORY

## Please Read

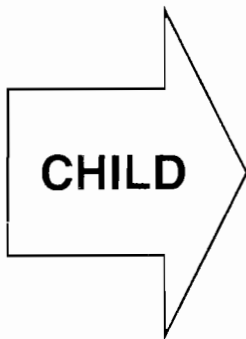
Will you kindly answer the following questions. In this office, we are very much interested in helping you with your program of health and well being. We feel that this interest in your appearance, comfort, and ability to chew, digest and enjoy your food is one of the reasons why you are here.

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**

<b>PLEASE PRINT</b>	<b>1</b>
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 _____	
<b>* If your child's name and address are not the same as yours, please fill in the box on top also.</b>	



<b>INSURANCE</b>	<b>2</b>
<b>Primary Carrier</b>	
Insurance Co. _____	
Ins. Tel. # _____	
Employer _____	
Union or Local # _____	
Group # _____	
Insured SS # _____	
<b>Secondary Carrier</b>	
Insurance Co. _____	
Ins. Tel. # _____	
Employer _____	
Union or Local # _____	
Group # _____	
Social Security # _____	

**JAY PISKIN, D.D.S.**

83 COVERT AVENUE  
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(516) 354-1213

**MEDICAL HISTORY:**

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

(PHONE #) \_\_\_\_\_

3. LAST COMPLETE PHYSICAL? \_\_\_\_\_
4. ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? .....  YES  NO  
IF YES, PLEASE EXPLAIN \_\_\_\_\_
5. HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE LAST 5 YEARS? .....  YES  NO  
IF YES, PLEASE EXPLAIN \_\_\_\_\_
6. ARE YOU TAKING ANY MEDICATION NOW? (PILLS, VITAMINS, SYRUP, ETC.).....  YES  NO  
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         | <input type="checkbox"/> | <input type="checkbox"/> | JAUNDICE, HEPATITIS OR LIVER DISEASE     | <input type="checkbox"/> | <input type="checkbox"/> |
| RHEUMATIC FEVER                       | <input type="checkbox"/> | <input type="checkbox"/> | ASTHMA OR HAY FEVER                      | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART MURMUR OR MITRAL VALVE PROLAPSE | <input type="checkbox"/> | <input type="checkbox"/> | SINUS TROUBLE                            | <input type="checkbox"/> | <input type="checkbox"/> |
| ABNORMAL BLOOD PRESSURE               | <input type="checkbox"/> | <input type="checkbox"/> | HIV OR AIDS                              | <input type="checkbox"/> | <input type="checkbox"/> |
| ULCERS                                | <input type="checkbox"/> | <input type="checkbox"/> | ARTHRITIS OR SORE JOINTS                 | <input type="checkbox"/> | <input type="checkbox"/> |
| TUBERCULOSIS OR LUNG DISEASE          | <input type="checkbox"/> | <input type="checkbox"/> | STROKE                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| DIABETES OR ANEMIA                    | <input type="checkbox"/> | <input type="checkbox"/> | GLAUCOMA                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| CONGENITAL HEART LESIONS              | <input type="checkbox"/> | <input type="checkbox"/> | VENEREAL DISEASE (SYPHILIS OR GONORRHEA) | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART VALVE OR JOINT REPLACEMENT      | <input type="checkbox"/> | <input type="checkbox"/> | CANCER, TUMORS OR GROWTHS                | <input type="checkbox"/> | <input type="checkbox"/> |
| OTHER _____                           | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
8. ARE YOU ALLERGIC TO ANY DRUGS OR MEDICATION SUCH AS PENICILLIN, CODEINE, ASPIRIN OR LOCAL INJECTED ANESTHETICS? .....  YES  NO  
IF YES, WHAT? \_\_\_\_\_
9. ANY ALLERGIES TO LATEX? .....  YES  NO
10. ARE YOU TAKING BLOOD THINNERS OR SUBJECT TO PROLONGED BLEEDING? .....  YES  NO
11. DO YOU HAVE EXCESSIVE URINATION AND/OR THIRST? .....  YES  NO
12. DO YOU USE TOBACCO? .....  YES  NO

**WOMEN:**

1. ARE YOU PREGNANT? .....  YES  NO

**DENTAL HISTORY:**

1. ARE YOU AWARE OF ANY DENTAL PROBLEMS AT THIS TIME? .....  YES  NO  
IF YES, PLEASE EXPLAIN \_\_\_\_\_
2. WHEN WAS YOUR LAST DENTAL VISIT? \_\_\_\_\_  YES  NO
3. ARE YOU SEEN IN A DENTAL OFFICE ON A REGULAR BASIS? .....  YES  NO  
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? .....  YES  NO
7. DO YOU HAVE A BAD TASTE OR ODOR IN YOUR MOUTH OR BEEN TOLD YOU HAVE BAD BREATH?..  YES  NO
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? .....  YES  NO  
IF YES, PLEASE EXPLAIN \_\_\_\_\_
11. ARE YOU FAMILIAR WITH THE TERM, "PREVENTIVE DENTISTRY"? .....  YES  NO
12. ARE YOU PLEASED WITH THE APPEARANCE OF YOUR TEETH? .....  YES  NO  
IF NOT, WHY? \_\_\_\_\_
13. DOES THE NOISE OF HIGH SPEED EQUIPMENT BOTHER YOU? .....  YES  NO
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