



# Berlin Dental Associates

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(856) 767-7077

## PATIENT HEALTH RECORD

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think we should have. Thank you for your cooperation.

Name *First* \_\_\_\_\_ *Middle* \_\_\_\_\_ *Last* \_\_\_\_\_ Today's Date \_\_\_\_\_

### TELL US ABOUT YOUR MEDICAL HEALTH

Date of Birth \_\_\_\_\_

How would you rate your general health?  Excellent  Good  Fair  Poor

Physician Information Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

Have you had major surgery in the past five years?  Yes  No  
If yes, when? \_\_\_\_\_ For what purpose? \_\_\_\_\_

Have you ever had or been treated for:

- |                                    |                              |                             |
|------------------------------------|------------------------------|-----------------------------|
| Heart Disease .....                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rheumatic Fever .....              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abnormal Blood Pressure .....      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ulcers .....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis or Lung Disease ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes .....                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy .....                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia .....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A.I.D.S. ....                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Murmur .....                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- |                       |                              |                             |
|-----------------------|------------------------------|-----------------------------|
| Cancer .....          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Jaundice .....        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma .....          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hay Fever .....       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sinus Trouble .....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis .....       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis .....       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke .....          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Glaucoma .....        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid Disease ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Are you taking medication now? If yes, for what purpose?  
Drug \_\_\_\_\_ Purpose \_\_\_\_\_  
Drug \_\_\_\_\_ Purpose \_\_\_\_\_  
Drug \_\_\_\_\_ Purpose \_\_\_\_\_

Do you take Anti-coagulants or blood thinners?  Yes  No

Have you ever taken Phen-Fen or products containing Ephedra?  Yes  No If yes, which one? \_\_\_\_\_

Are you allergic to:  Penicillin  Codeine  Local injected anesthetics  Latex  Other \_\_\_\_\_

Have you ever been told you need premedication for dental treatment?  Yes  No If yes, why? \_\_\_\_\_

Are you HIV positive?  Yes  No

Are you subject to prolonged bleeding?  Yes  No

Have you ever had a blood transfusion?  Yes  No

Women: Are you pregnant?  Yes  No Due Date \_\_\_\_\_  
OB/GYN Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Are you Nursing?  Yes  No

Do you have any prosthetic joint, hip, valve?  Yes  No

Do you have any disabilities or handicaps?  Yes  No If so, what? \_\_\_\_\_

Do you use tobacco products?  Yes  No If yes, what type and how often? \_\_\_\_\_

Is there any other information you would like the doctor to know? \_\_\_\_\_

Patient Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

I (Parent if under 18) certify that all the above responses are correct to the best of my knowledge & I hereby authorize treatment.

# DENTAL HEALTH

Reason for seeking dental care today: \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Have you ever had any problems associated with previous dental treatment?  Yes  No

If so, explain? \_\_\_\_\_

Are you anxious or nervous about dental care?  Yes  No

How often do you brush your teeth? \_\_\_\_\_

What texture brush do you use:  Soft  Medium  Hard

Do you floss?  Yes  No

Do your gums bleed while brushing?  Yes  No

Do your gums bleed while flossing?  Yes  No

Have you ever had brushing and flossing instructions?  Yes  No

Do you avoid brushing any part of your mouth because of pain?  Yes  No

If yes, what part? \_\_\_\_\_

Do you feel twinges of pain when you come in contact with:

a) hot foods or liquid, i.e., soup, coffee, tea, etc.?  Yes  No

b) cold foods or liquids, i.e., ice cream, cold fruit, etc.?  Yes  No

c) sweets, i.e., candy, fruit, sweet deserts, etc.?  Yes  No

d) sours, i.e., lemons, limes, grapefruit, etc.?  Yes  No

Do you feel pain to any of your teeth when brushing or flossing them?  Yes  No

Do you chew on only one side of your mouth?  Yes  No

If yes, explain? \_\_\_\_\_

Do your gums feel tender and swollen?  Yes  No

Do you clench or grind your jaws while sleeping or during the day?  Yes  No If so, which? \_\_\_\_\_

Do your jaws ever feel tired?  Yes  No

Do you wear dentures or partials?  Yes  No

Do you gag easily?  Yes  No

Have you ever had treatment for a TMJ problem?  Yes  No

Please add anything else you feel the doctor should know: \_\_\_\_\_

\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

I verbally reviewed the medical/dental information above with the patient

## Doctor/Dental Auxilliary Signature

## Date

### MEDICAL HISTORY UPDATES

DATE REVIEWED BY

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

DATE REVIEWED BY

4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

### BLOOD PRESSURES

DATE REVIEWED BY

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

DATE REVIEWED BY

4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_