Patient Health Evaluation

Patient Registration & Medical/Dental Health Evaluation

Date of Eval:_____ **Dr/Hyg:**_____

1 PATIENT INFORMATION

Date _____

Patient Name _____

Preferred Name _____

Address _____

City _____

State _____ Zip _____

Email _____ SSN# _____

Sex M F

Age _____ Birth date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Spouse's Name _____

Spouse Employer _____ Occupation _____

Pharmacy Name _____ Phone _____

Whom may we thank for referring you? _____

Please check the way you heard about us:

☐ TV ☐ Radio ☐ Family/Friend

☐ Location ☐ Print Ad ☐ Other _____

2 PHONE NUMBERS

Home _____ Cell _____

Work _____ Ext _____

Best Time & Place to reach you _____

Spouse's Work Phone _____

Spouse's Cell Phone _____

In case of emergency Contact: *(Specify someone not in household)*

Name _____

Relationship _____

Home Phone _____

Cell Phone _____

Work Phone _____

3 HEALTH HISTORY MEDICAL HISTORY

Physician's Name _____

Phone _____

Are you under a physicians care now? ☐ Yes ☐ No

For what condition(s) are you being treated? _____

_____

Date of last Visit _____ Reason for Visit _____

Date of last Physical _____

Place a mark on "Yes" or "No" to indicate of you have or have had any of the following:

Heart

Angina/Chest Pain	☐ Yes	☐ No
Artificial Valves	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No
Heart Attack/Failure	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Trouble/Disease	☐ Yes	☐ No
Irregular Heart Beat	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Pace Maker	☐ Yes	☐ No

Other _____

Advised to take Pre-Med Antibiotics ☐ Yes ☐ No

If yes, what Antibiotics? _____

Prior to Dental TX: ☐ Yes ☐ No Reason for Premed: _____

Vascular

High Blood Pressure	☐ Yes	☐ No

Baseline _____

Stroke	☐ Yes	☐ No

Take blood thinners? Type _____

Blood Transfusion	☐ Yes	☐ No

When _____

Excessive Bleeding	☐ Yes	☐ No

Explain _____

Blood Disease	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Daily Aspirin	☐ Yes	☐ No

Other _____

Pulmonary

Asthma	☐ Yes	☐ No
Inhaler	☐ Yes	☐ No

If yes, where do you carry in case of emergency _____

Shortness of Breath / Easily Winded	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Fainting / Dizziness	☐ Yes	☐ No

Other _____

Cancer

Type: _____

Date(s): _____

Types of Treatment: ☐ Surgery ☐ Chemo ☐ Radiation

Infectious Disease

Hepatitis A	☐ Yes	☐ No
Hepatitis B or C	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No

Other Systems

Anemia	☐ Yes	☐ No
Arthritis (Type)_____	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
☐ Uncontrolled	☐ Yes	☐ No
☐ Controlled by_____	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Depression/Psychiatric Care (Circle)	☐ Yes	☐ No
Seizure Disorder	☐ Yes	☐ No

Type _____

Date of Last Seizure _____

Precipitating Factors _____

Alzheimer's Disease	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No
Knee / Hip / Other_____ Premed Needed?	☐ Yes	☐ No

If yes, what Antibiotics? _____

Doctor _____ Date of Surgery: _____

Thyroid Disease	☐ Yes	☐ No

Type: _____ Past Complications _____

Gastric Reflux/GERD/Consistent Heart burn	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No

Explain _____

Drug Addiction	☐ Yes	☐ No

Past / Present (circle)

Recreational Drug Use within Past 3 Years	☐ Yes	☐ No

Scanned: _____

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Medications

List any Medications you are currently taking & Correlating Reason:

(Provide Separate list if necessary)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Antibiotics

☐ Other _____

Women:

Are you pregnant presently? ☐ Yes ☐ No

Due Date_____

Trying to get pregnant ☐ Yes ☐ No

Taking oral contraceptives ☐ Yes ☐ No

Nursing ☐ Yes ☐ No

4 DENTAL HISTORY

A. Reason for today's visit & your immediate concern _____

_____

_____

List all current dental problem(s) concern(s) _____

_____

_____

_____

Tooth Sensitivity:

☐ Cold ☐ Pain ☐ Hot ☐ Sweets ☐ Swelling ☐ Ache

☐ Biting or Chewing

How would you rate the condition of your mouth?:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unsure

B. Former/Previous Dentist _____

Address _____

Date of Most Recent Exam/Cleaning_____

Date of Most Recent treatment _____

What was performed? _____

In the past I have seen my dentist every ☐ 3 mo ☐ 4 mo ☐ 6 mo

☐ 12 mo ☐ not routinely

C. Personal Dental History:

Are you fearful of Dental Treatment? ☐ Yes ☐ No

Upsetting dental experience? ☐ Yes ☐ No Explain _____

_____

Complications with previous dental treatment? ☐ Yes ☐ No

Back problems/difficulty sitting in dental chairs? ☐ Yes ☐ No

Unusual bleeding with previous dental treatment? ☐ Yes ☐ No

Have you had trouble getting Numb or Reactions to local Anesthetics?

Explain _____

_____

D. Home Care

Type of toothbrush: ☐ Regular ☐ Battery Spin Brush ☐ Rechargeable

Type of Toothpaste _____

When/How often do you Brush? _____

When/How often do you Floss?_____

Do you brush or scrape your tongue? _____

E. Gum and Bone

Have you been Diagnosed or treated for periodontal (gum or bone) disease? ☐ Yes ☐ No

Explain_____

Family History of Periodontal (Gum) Disease? ☐ Yes ☐ No

Family History of Tooth loss? ☐ Yes ☐ No

Smoke / Chewing Tobacco (circle)

How often?_____ when did you start?_____

Have you considered Stopping? ☐ Yes ☐ No

Unpleasant taste or odor in your mouth? ☐ Yes ☐ No

Mouth odor / Bad taste / Bad breath (circle)

Gums bleed when brushing, flossing or eating? ☐ Yes ☐ No

Gums tender? ☐ Yes ☐ No

Swollen gums? ☐ Yes ☐ No

Do you notice loose teeth? ☐ Yes ☐ No

Gum Recession (shrinking)? ☐ Unsure ☐ Yes ☐ No

Mouth Breath (awake or asleep)? ☐ Unsure ☐ Yes ☐ No

Snore ☐ Unsure ☐ Yes ☐ No

Cold sores/fever blisters on lips or mouth? ☐ Yes ☐ No

Location_____

Frequency _____

Meds previously used _____

F. Bite and Jaw Joint

Clench? Day / Night (circle) ☐ Unsure ☐ Yes ☐ No

Grind? Day / Night (circle) ☐ Unsure ☐ Yes ☐ No

Tired Jaws? ☐ Yes ☐ No Especially in A.M? ☐ Yes ☐ No

Have you ever had your Bite adjusted? ☐ Yes ☐ No

Jaw / Joint pain? (circle) ☐ Yes ☐ No

Bite plate/night guard? ☐ Yes ☐ No

Click/pop of jaw? ☐ Yes ☐ No

Pain around ear(s) ☐ Yes ☐ No

Difficulty: Opening / Closing (circle) ☐ Yes ☐ No

Frequent/consistent headaches? (AM/PM) ☐ Yes ☐ No

Do you notice:

Changes in bite? ☐ Yes ☐ No

Difficulty chewing on either side of mouth? ☐ Yes ☐ No

G. Tooth Alignment

Previous orthodontic treatment (braces/invisalign) ☐ Yes ☐ No

Date(s)/Age:_____Retainer currently ☐ Yes ☐ No

Happy with results ☐ Yes ☐ No

Relapse/desire to learn options to correct? ☐ Yes ☐ No

Food catches between teeth? ☐ Yes ☐ No

Location(s)_____

Crooked/crowded? ☐ Yes ☐ No

Concerns_____ ☐ Yes ☐ No

Excessive space? ☐ Yes ☐ No

Concerns_____ ☐ Yes ☐ No

Interested to learn more about options? ☐ Yes ☐ No

H. Smile

Desire to learn more about options to enhance smile? ☐ Yes ☐ No

Explain: _____

_____

Concern with color of teeth/smile ☐ Yes ☐ No If yes, explain_____

_____

Have you ever considered whitening ☐ Yes ☐ No

Patient Signature: _____

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ANGELOPULOS
COSMETIC & GENERAL
DENTAL

Please take a moment to observe your teeth carefully and answer the questions below. Your response enables us to understand your expectations and concerns about your dental health.

1. On a scale of 1 to 10, how do you feel about your teeth and smile? 1 meaning you don't like anything, 10 meaning everything is great! _____
2. Are you concerned about the color of your teeth? _____
   _____
3. Do you like the shape of your teeth? _____
   _____
4. Do you have spaces that you don't like? _____
   _____
5. Are your teeth... all in alignment? Straight? Crooked? Crowded? _____
   Is this a concern? _____
6. Are your teeth... chipped? Protruding? Hidden? _____
   _____
7. Are there old fillings or dental work you don't like looking at? _____
   _____
8. Is there anything about the appearance of your teeth that you would like to change? _____
   _____
9. Tell us about your smile. Do you like the appearance of your teeth? _____
   _____
10. How would you like your teeth to look? _____
    _____
11. Have you been disappointed with the appearance of previous dental work? Please explain. _____
    _____

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