

PINADELLA DENTAL  
**PATIENT HEALTH RECORD**

**DATE:** \_\_\_\_\_ **Email:** \_\_\_\_\_

Mr./ Mrs./ Ms. : \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First) (Initial)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Home #: \_\_\_\_\_ Cell: \_\_\_\_\_

**Sex:** M / F **Marital Status:** Married / Single / Child

Social Security #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Medical History**

What is your general state of health? Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Name, address and phone number of physician: \_\_\_\_\_

Have you been under a physician's care during the last two years? \_\_\_\_\_

Have you been treated in a hospital in the past three years? \_\_\_\_\_

Have you had any minor or major surgery? Please explain \_\_\_\_\_

History with local, general and IV anesthesia? \_\_\_\_\_

If Female: Are you pregnant or nursing? \_\_\_\_\_

**Do you or have you had any of the following:**

	None	Present	Past		None	Present	Past		None	Present	Past
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise/Bleeds easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis/PPD+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Proplapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A / B / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis /Penia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness/Anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any conditions, disease, or problems not previously listed? \_\_\_\_\_

Please list any medications you are taking, including over the counter drugs and herbs.  
 \_\_\_\_\_

Dental Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Please add anything you feel is important \_\_\_\_\_

\_\_\_\_\_  
Signature Patient or Guardian

\_\_\_\_\_  
Date