

# PATIENT HEALTH RECORD

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
Name you wish to be called \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  Single  Married Spouse's Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ eMail \_\_\_\_\_  
Closest Relative/Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Whom may we thank for referring you to our practice? \_\_\_\_\_

## MEDICAL HEALTH

Name of physician \_\_\_\_\_ Phone Number \_\_\_\_\_  
Have you been under a physician's care in the last 2 years? \_\_\_\_\_ For \_\_\_\_\_  
Have you been treated in a hospital in the last 2 years? \_\_\_\_\_ For \_\_\_\_\_  
Have you ever had major surgery? \_\_\_\_\_ For \_\_\_\_\_  
If female: Are you taking Birth Control? \_\_\_\_\_ Hormones? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_  
Please list all medications and dosage you have taken during the past year, including prescription, non-prescription, recreational:  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to:  Latex  Penicillin  Local Anesthetics  Codeine/Narcotics  
Other (please list) \_\_\_\_\_

Are you taking or have you ever taken any of these?  Fosamax  Actonel  Boniva  Didronel  Skelid  
 Aredia  Bonfos  Zometa

Have you ever had or do you now have:

- | Yes                      | No                       |   | Yes                      | No                       |  |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal blood pressure (high or low)                 | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease or Attack                  |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS, ARC, HIV positive                               | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur (Mitral Valve Prolapse, eg) |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies or Hives                                    | <input type="checkbox"/> | <input type="checkbox"/> | Heart Pacemaker                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia  | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis (Either A , B or C)            |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina (Chest Pains)                                  | <input type="checkbox"/> | <input type="checkbox"/> | Herpes (Type I or II)                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety   | <input type="checkbox"/> | <input type="checkbox"/> | Implant (Joint, Eye, Breast, or other)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve(s)                             | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint(s)                                   | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease (Jaundice, Cirrhosis)      |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma  | <input type="checkbox"/> | <input type="checkbox"/> | Organ Transplant                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Disorders or Taking Blood Thinners           | <input type="checkbox"/> | <input type="checkbox"/> | Polio                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Test or Vaccination for Hepatitis               | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Bleeding                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusions                                    | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Cough                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer or Tumor                                       | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Treatment                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Cankers or Cold Sores (Mouth or Body)                 | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy  | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect(s)                            | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Cortisone or Steroid Treatment                        | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (Adult or Juvenile Onset)                    | <input type="checkbox"/> | <input type="checkbox"/> | Special Diet                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Dependency (Pharmaceutical, Alcohol, or Tobacco) | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema   | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizures                                  | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB)                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizzy Spells                              | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers (Stomach, Intestine, Mouth)       |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma  | <input type="checkbox"/> | <input type="checkbox"/> | Veneral Disease (Sexually Transmitted)   |

What other disease, condition, or problem do you have that is not previously listed? \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I understand I must notify Dr. Mullens and/or his staff immediately at any time my information changes.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize the release of medical/dental information to any of the following if needed: My physician or other physician I am referred to, other dental offices I may be referred to, attorneys (with my prior release by signature), and my insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand Dr. Mullens may photograph my face and mouth for the purpose of documentation in my record. \_\_\_\_\_ (Initial)

I further grant my permission to use my photographs for educating other patients, including placing them on his website.

Signature \_\_\_\_\_ Date \_\_\_\_\_