PATIENT HEALTH RECORD

We care about you and your well-being.
For that reason we ask you to complete this health history.

LEIPNITZ DENTAL CLINIC, S.C.
2521 South Broadway
Menomonie, WI 54751
(715) 235-7371

Name_____ Date_____
Birthdate _____ Phone_____

MEDICAL HEALTH

Physician Name / Clinic Name / Telephone #_____
Last complete physical_____ Pharmacy Name_____

Circle any of the following which you have had:

Abnormal Blood Pressure
Alzheimer's Disease
Anemia
Angina
Artificial Heart Valve
Asthma / Hay Fever
Blood Thinners
Blood Transfusion
Chemotherapy
Congenital Heart Lesions (Defects)
Diabetes / Insulin-Dependent
Drug / Alcohol Abuse
Emphysema
Epilepsy / Convulsions
Fever Blisters / Herpes
Glaucoma
Heart Attack
Heart Disease
Hemophilia / Abnormal Bleeding
Hepatitis
HIV / AIDS
Jaundice
Joint Replacements
Kidney Problems / Dialysis
Lupus (SLE)
Malignancy (Cancer)
Mental Illness
Mitral Valve Prolapse
Nervous Problems
Pacemaker
Radiation Treatments
Rheumatic Fever
Rheumatoid Arthritis
Scarlet Fever
Shingles
Sinus Problems
Stroke
Tuberculosis / Lung Disease
Ulcers / Colitis
Venereal Disease

Have you ever had any other serious illnesses, injuries, or surgeries?.....Y/N
Please explain_____
Are you taking any medication?.....Y/N
What are they?_____
Have you taken or are you currently taking bisphosphonates
(example: Fosamax, Boniva, Actonel)……..…….....…….Y/N
Are you using oral contraceptives?.....Y/N
Do you smoke or chew tobacco?.....Y/N
Are you pregnant?.....Y/N
Due date: _____
List allergies:_____

DENTAL HEALTH

If this is your first visit with us, what is your main concern? _____
When was your last dental visit? _____
Have you ever had any problems with previous dental treatment?.....Y/N
If so, explain: _____ _____
Do your gums bleed while brushing or flossing?.....Y/N
Do your gums feel tender or swollen?.....Y/N
Do you feel pain when your teeth come in contact with hot, cold, sweet, sour or pressure?..... Y/N
Do you clench or grind your teeth while sleeping or awake?..... Y/N
Do your jaws ever feel tired?.....Y/N
How often do you brush your teeth? _____ How often do you floss? _____
What texture toothbrush do you use? soft medium hard nylon natural

_____
Signature