insight
integrative dentistry

Patient Health Information

Correct answers to the following questions will allow us to treat you on a more individual basis.
Your answers are for our records only and will be considered confidential.

Have you ever had any of the following? Please check all that apply.

- ☐ AIDS or HIV
- ☐ Allergies _____
- ☐ Arthritis
- ☐ Artificial joints or hip
- ☐ Asthma
- ☐ Blood disorder
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Emphysema
- ☐ Excessive bleeding or bruising
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Head trauma
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High/low blood pressure
- ☐ Kidney disease
- ☐ Latex sensitivity
- ☐ Liver disease
- ☐ Mental disorders
- ☐ Nervous disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Respiratory problems
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Sinus problems
- ☐ Sleep disorders
- ☐ Special diet
- ☐ Stomach problems
- ☐ Stroke
- ☐ Thyroid condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Weight loss / gain of 10 pounds in past year

Are you currently: Pregnant ☐ Yes ☐ No Nursing ☐ Yes ☐ No Taking oral contraceptives ☐ Yes ☐ No

Do you have any allergies or adverse reactions to medications? ☐ Yes ☐ No

If yes, please list: _____

Do you have any health problems? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had complications during or following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you been hospitalized or had any serious illness or operations? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of physician _____ Phone _____ Date of your last physical _____

Are you currently taking any medications or dietary/herbal supplements? ☐ Yes ☐ No

If yes, please list: _____

Medication dosage condition being treated

a. _____ b. _____

c. _____ d. _____

To the best of my knowledge, all answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

X _____ Date _____

Signature of patient, parent or guardian

Personal Overall Health Assessment

Please rate each of the following symptoms based on your typical health profile over the past year.

POINT SCALE:	
0 =	Never have the symptom
1 =	Almost never have the symptom
2 =	Occasionally have it, effect is not severe
3 =	Occasionally have it, effect is severe
4 =	Frequently have it, effect is not severe
5 =	Frequently have it, effect is severe

ENERGY / ACTIVITY	
	Fatigue, sluggishness
	Apathy, lethargy
	Hyperactivity
	Restlessness
	Easy fatigability or lack of endurance
	Headaches
	Faintness
	Dizziness
	Insomnia

EMOTIONAL / MENTAL	
	Mood swings
	Anxiety, fear or nervousness
	Anger or irritability
	Depression
	Poor memory
	Confusion, poor comprehension
	Poor concentration
	Difficulty making decisions
	Stuttering or stammering
	Slurred speech
	Learning disabilities

JOINTS / MUSCLES / SKIN	
	Pain or aches in joints
	Stiffness or limitation of movement
	Pain or aches in muscles
	Feeling of weakness or tiredness
	Cramps in legs
	Acne
	Hives, rashes or dry skin
	Hair loss
	Flushing or hot flashes
	Fingernail abnormalities (spots, ridges)
	Decreased sweating
	Night sweats

EARS / MOUTH / THROAT / NOSE / EYES	
	Itchy ears
	Earaches, ear infections
	Ringing in ears or hearing loss
	Drainage from ears
	Stuffy nose
	Sinus Problems
	Hay fever
	Excessive mucus formation
	Sneezing attacks
	Poor night vision
	Watery or itchy eyes
	Swollen, tender or sticky eyelids
	Bags or dark circles under eyes
	Blurred or tunnel vision
	Chronic cough
	Sore throat, hoarseness or voice loss
	Swollen or discolored tongue, gums, lips
	Canker sores

DIGESTIVE TRACT	
	Nausea or vomiting
	Diarrhea
	Constipation
	Bloated feeling
	Belching or passing gas
	Heartburn

HEART / LUNGS	
	Irregular heartbeat
	Rapid or pounding heartbeat
	Chest pain
	Chest congestion
	Asthma, bronchitis
	Shortness of breath

WEIGHT / OTHER	
	Binge eating/drinking
	Food cravings
	Excessive weight
	Water retention
	Underweight
	Frequent illness
	Frequent or urgent urination
	Injury