RONALD F. KONOPKA, D.D.S.
PATIENT HEALTH RECORD

The following information is requested to assist the Doctor and staff in providing dental care that is compatible with your general health. This is a confidential form. Your answers should be as complete as possible. Please *circle* Yes or No as needed.

Date_____

Name_____Date of Birth_____Height_____Weight_____

Why have you come to the dentist today?_____

DENTAL HISTORY

Date of your last cleaning_____ Last exam_____
Date of last full mouth x-rays (16-18 small films or panoramic)_____Last cavity detection x-rays_____
Name of dentist you saw_____
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? _____ Yes No
Do your gums ever bleed? Discuss _____Yes No
Does food catch between your teeth? Any loose teeth? _____Yes No
Do you ever have clicking, popping, or discomfort in the jaw joint? Do you grind your teeth? _____Yes No
Any sores or growths in your mouth? Discuss _____ Yes No
Do you have a history of cold sores, fever blisters, or canker sores_____ Yes No
Have your past experiences in a dental office always been positive? _____Yes No
Is there anything about your smile that you would like to change?_____ Yes No

MEDICAL HEALTH

Name and phone number of your physician
_____
Are you presently under the care of your physician? Yes No
If so, for what reason?
_____
Are you taking any prescription medications now? Yes No Over-the-counter medications? Yes No Herbal medications? Yes No
If Yes, please list all medications.
_____

_____

_____
Are you allergic to: Antibiotics Yes No Codeine Yes No Aspirin Yes No Local Anesthetics Yes No Latex Yes No

Or any other medications?
_____
Have you been hospitalized in the last five years? Yes No
If Yes, give reason and approximate date(s).
_____

_____
Have you had medical diagnostic x-rays in the last five years? Yes No
Have you had or you now having chemotherapy or radiation treatment? Yes No
Have you had any blood transfusions? Yes No
Have you experienced any recent weight change? Yes No Gain Loss
Do you take any medications to help in weight reduction? Yes No Fen-Phen or Redux used Yes No
Have you had biphosphonate therapy? Oral or Intravenous? Yes No
Do you smoke? Yes No _____Pack(s)/Day
Do you consume alcohol on a daily basis? Yes No
Is your blood pressure Normal Low High

Women: Are you pregnant? Yes No How long?_____ Do you take birth control pills? Yes No
PLEASE COMPLETE OTHER SIDE OF THIS FORM (TURN OVER)

Do you have or have you ever been informed that you had any of the following:

Artificial Heart Valve Replacement	Yes	No	Epilepsy or Seizures	Yes	No	AIDS	Yes	No
Congenital Heart Disease	Yes	No	Luekemia/Anemia	Yes	No	HIV Positive	Yes	No
History of Bacterial Endocarditis	Yes	No	Cancer/Tumor or Growth	Yes	No	Persistent Diarrhea	Yes	No
Acquired Valvular Heart Disease	Yes	No	Mental Health Problems	Yes	No			
Heart Murmur/Rheumatic Fever	Yes	No	Sickle Cell Disease	Yes	No	Osteoporosis	Yes	No
Prolapsed Heart Valve	Yes	No	Glaucoma	Yes	No	Pagets Disease	Yes	No
Chest Pain upon Exertion	Yes	No	Prosthetic Joint Replace-	Yes	No			
Hypertension	Yes	No	ment(when_____)					
			Any problems with the joint since it was replaced	Yes	No			
Kidney Disease/Malfunction	Yes	No	Jaundice	Yes	No			
Stroke	Yes	No	Allergies or Hives	Yes	No			
Thyroid Problems	Yes	No	Sinus Trouble	Yes	No			
Hormonal Problems	Yes	No	Arthritis	Yes	No			
Ulcers	Yes	No	Persistent Cough	Yes	No			
Asthma or Hay Fever	Yes	No	Prolonged Bleeding	Yes	No			
Tuberculosis or Lung Disease	Yes	No	Genetic Disease	Yes	No			
Diabetes	Yes	No	Skin Disease	Yes	No			
Excessive Urination/Thirst	Yes	No	Sexually Transmitted Disease	Yes	No			

Have you ever tested positive for Hepatitis(type_____)? Yes No
Organ Transplantation? Yes No
Artificial implant or graft of any other than listed above (list_____)? Yes No
Are you being treated with immunosuppressive drugs? Yes No
Do you use drugs for recreational purposes? Yes No

_____
Signature Date
Reviewed by Date

MEDICAL UPDATES:

Date	Changes in medical conditions	Patient Signature	Reviewed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____