MICHAEL T. GMITRUK D.D.S.

NEW PATIENT HEALTH RECORD

DATE_____

PATIENT NAME _____
(LAST) (FIRST) (MIDDLE)

SPOUSE OR
LEGAL GUARDIAN _____
(LAST) (FIRST) (MIDDLE)

COMPLETE ADDRESS _____
(STREET) (CITY) (STATE-ZIP)

HOME PHONE _____ WORK PHONE_____

E-MAIL ADDRESS_____

PLACE OF EMPLOYMENT_____OCCUPATION_____

DATE OF BIRTH_____ SEX_____ SS NUMBER _____ - ____ -_____

IF YOU ARE COMPLETING THIS FORM FOR A PATIENT WHAT IS YOUR NAME AND YOUR RELATIONSHIP TO PATIENT:_____

HOW DID YOU FIND OUT ABOUT OUR SERVICES? _____

MEDICAL HEALTH RECORD:

GENERAL HEALTH EXCELLENT___ GOOD___ FAIR___ POOR___

NAME AND ADDRESS OF PHYSICIAN: _____

LAST VISIT TO PHYSICIAN_____FOR WHAT REASON_____

ARE YOU TAKING ANY MEDICATION(S) YES____ NO____

PLEASE LIST MEDICATION(S) YOU ARE CURRENTLY TAKING_____

HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATIONS ? YES___NO___

PLEASE DESCRIBE:_____

HAVE YOU HAD OR DO YOU HAVE:

HEART DISEASE	YES___NO___	ANGINA	YES___NO___
HIGH BLOOD PRESSURE	YES___NO___	ASTHMA	YES___NO___
LOW BLOOD PRESSURE	YES___NO___	COUGH	YES___NO___
TUBERCULOSIS	YES___NO___	LUNG DIS.	YES___NO___
SINUS TROUBLE	YES___NO___	HEPATITIS	YES___NO___
DIABETIC	YES___NO___	ARTHRITIS	YES___NO___
EPILEPSY	YES___NO___	STROKE	YES___NO___
ANEMIA	YES___NO___	GLAUCOMA	YES___NO___
CONGENITAL HEART	YES___NO___	HERPES	YES___NO___
HEART MURMUR, MVP	YES___NO___	AIDS	YES___NO___
JAUNDICE	YES___NO___	JOINT REPL	YES___NO___
PACEMAKER	YES___NO___	ULCERS	YES___NO___

HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST 5 YEARS? _____

IF YES, WHY_____

HAVE YOU EVER BEEN TREATED WITH RADIATION THERAPHY?_____

ARE YOU ALLERGIC TO: PENICILLIN_____ CODEINE_____
LOCAL INJECTED DRUGS_____ OTHER MEDICATIONS_____

ARE YOU SUBJECT TO PROLONG BLEEDING?_____

ARE YOU SUBJECT TO FAINTING SPELLS?_____

DO YOU HAVE EXCESSIVE URINATION OR THIRST?_____

FOR WOMEN ONLY
ARE YOU PREGNANT? YES___ NO___ HOW FAR ALONG?_____
IS THERE A POSSIBILITY THAT YOU MAY BE PREGNANT?_____
IF JUST GIVEN BIRTH ARE YOU NURSING?_____

WHEN WAS YOUR LAST DENTAL VISIT?_____
REASON FOR LAST DENTAL VISIT?_____

HAVE YOU EVER HAD A SERIOUS PROBLEM ASSOCIATED WITH PREVIOUS DENTAL TREATMENT?
_____

HOW OFTEN DO YOU BRUSH YOUR TEETH?_____

WHAT TEXTURE TOOTH BRUSH DO YOU USE? SOFT_____MEDIUM_____HARD_____NYLON_____NATURAL_____

HOW OFTEN DO YOU FLOSS?_____
DO YOU CHEW ON ONLY ONE SIDE OF YOUR MOUTH?_____
DO YOUR GUMS BLEED WHILE BRUSHING?_____
DO YOU AVOID BRUSHING ANY PART OF YOUR MOUTH DUE TO PAIN?
IF YES, WHAT AREA._____

DO YOUR GUMS FEEL TENDER OR SWOLLEN?	YES___NO___
DO YOUR CLENCH YOUR TEETH?	YES___NO___
DO YOU GRIND YOUR TEETH AT ANYTIME?	YES___NO___
DO YOUR JAWS EVER FEEL TIRED?	YES___NO___
DO YOU WEARS DENTURES?	YES___NO___
DO YOU USUALLY HAVE CAVITIES?	YES___NO___
DO YOU LOOSE OR BREAK FILLINGS?	YES___NO___
DO YOU GAG EASILY?	YES___NO___
DO YOU WORRY ABOUT BAD BREATH?	YES___NO___

IF YES, SPEAK WITH ANYONE ON OUR STAFF AND WE CAN HELP YOU.

ARE YOU FAMILIAR WITH THE TERM "PREVENTIVE DENTISTRY"? _____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR TEETH OR SMILE WHAT WOULD THAT BE?
_____

IS THERE ANYTHING ABOUT YOUR PAST OR PRESENT DENTAL OR MEDICAL HEALTH THAT DR. GMITRUK SHOULD KNOW ABOUT? IF YES PLEASE EXPLAIN.
_____
_____

I CERTIFY THAT I HAVE READ UNDERSTOOD AND PERSONALLY REVIEWED THE ABOVE QUESTIONS AND ANSWERS AND THAT TO THE BEST OF MY KNOWLEDGE THEY ARE CORRRECT AND TRUE. IF I EVER HAVE ANY CHANGE IN MY HEALTH OR MEDICINES I WILL INFORM DR. GMITRUK AT THE NEXT APPOINTMENT WITHOUT FAIL.
PATIENT SIGNATURE_____

THANK YOU FOR FILLING OUT THIS FORM. IT IS A GREAT TOOL IN TREATING YOU, OUR PATIENT, IN THE BEST WAY POSSIBLE.

MICHAEL T. GMITRUK D.D.S.