Reece & Jouett
EXCEPTIONAL DENTISTRY

Patient Health Survey

Patient Name _____ Address w/ Zip _____

Employer _____ Work Phone # _____

Home Phone # _____ Cell Phone # _____

Email _____ SSN _____

Primary Physician's Name _____ Physician Phone # _____

Date of Last Physical _____ Date of Birth _____

Spouse Name _____ Spouse Phone # _____

Emergency Contact _____ Contact Phone # _____

Place a mark on "yes" or "no"

AIDS/HIV	☐Yes ☐No	Epilepsy	☐Yes ☐No	Pacemaker	☐Yes ☐No
Anemia	☐Yes ☐No	Facial Pain	☐Yes ☐No	Posture Problems	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Fainting or dizziness	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Glaucoma	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Grinding	☐Yes ☐No	Ringing Ears	☐Yes ☐No
Asthma	☐Yes ☐No	Headaches	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Bell's Palsy	☐Yes ☐No	Heart Lesions	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Bleeding abnormally, with extractions or surgery	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
		Heart Problems	☐Yes ☐No	Sleep Apnea	☐Yes ☐No
Blood Disease	☐Yes ☐No	Hepatitis Type ___	☐Yes ☐No	Stroke	☐Yes ☐No
Cancer	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Swollen Feet or Ankles	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Jaw Popping	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Clenching	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Congested Ears	☐Yes ☐No	Limited Opening	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	Liver Disease	☐Yes ☐No	Tumor or growth	☐Yes ☐No
Cough, persistent	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	on Head/Neck	
Diabetes	☐Yes ☐No	Neck Ache	☐Yes ☐No	Ulcer	☐Yes ☐No
Dizziness	☐Yes ☐No	Nervous Problems	☐Yes ☐No		

List any medications you are currently taking: Please include any blood thinning medications or aspirin.

_____

_____

Are you allergic to any medications or other substances?

_____

_____

Have you taken or currently taking medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?
__Yes __No List Medication _____

Circle if you have seen: **an Orthodontist - had your bite adjusted - had any bite treatment - TMJ Joint Surgery**

Circle of you have seen any of the following healthcare professionals: **ENT, Neurologist, Chiropractor, or Massage Therapist.**

Have you ever had **Botox** and/or **Facial Fillers** __Yes __No
Do you snore, use a CPAP or had a sleep study? __Yes __No
Have you had radiation to the head and / or neck?__Yes __No

Do you use tobacco products?__Yes __No

Pharmacy Name: _____
Pharmacy Location: _____
Pharmacy Phone Number: _____

Signature: _____ Date: _____

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