ANDREW GODZYK, D.M.D.

• ORTHODONTICS •

Please Print Legibly

PATIENT HEALTH RECORD

_____

DATE

_____

NAME (Last) (First) (Middle)

MEDICAL HEALTH: Excellent _____ Fair _____ Poor _____

Name and address of Physician: _____

_____

_____

Date of last visit: _____

Have you ever been treated for:	Yes	No		Yes	No
Heart Disease			Anemia		
Rheumatic Fever			Congenital heart lesions		
Abnormal blood pressure			Heart murmur		
Ulcers			Asthma		
Tuberculosis or lung disease			Osteoporosis		
Diabetes			Hepatitis		
Epilepsy			Arthritis		
Glaucoma			AIDS or HIV positive		

Are you subject to prolonged bleeding? _____ _____

Are you subject to fainting spells? _____ _____

Do you have excessive urination and/or thirst? _____ _____

(Women) Are you pregnant? No _____ Yes _____ Due Date _____

Are you taking any medication now? No _____ Yes _____

For what purpose? _____

Do you have any allergies? No _____ Yes _____ If Yes, please list them _____

_____ _____ _____

Are there any other medical conditions that we should be aware of? No _____ Yes _____

If Yes, please list them _____

_____

DENTAL HEALTH:

Name and address of Dentist: _____

_____

Date of last visit: _____

	Yes	No
Do your gums bleed while brushing?		
Do you have sensitive teeth?		
Do you clench you jaws or grind your teeth while sleeping?		
or during the day?		
Have you ever had speech or tongue therapy?		
Do you play a musical instrument with your mouth?		
Did you suck thumb or fingers past 5 years of age?		
Have you ever had previous orthodontic treatment?		
If, by whom? _____		
Have you ever had an accident to the face, jaws, or teeth?		

If so, when? _____

(Date)