



ADULT HEALTH HISTORY FORM

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: First _____ Middle _____ Last _____ Home Phone: _____ Cell Phone: _____

Address: Street _____ City _____ State _____ Zip _____ Email: _____

Date of Birth: MM ____ / DD ____ / YYYY ____ Social Security Number or Patient ID: _____ Height: _____ Weight: _____ Sex: M F

Occupation: _____ Company: _____

Emergency Contact: _____ Relationship: _____ Home Phone: _____ Cell Phone: _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____ Cell Phone: _____

Do you have any of the following disease or problems: Y N ? Y N ?

Active Tuberculosis Persistent cough greater than a 3 week duration.....

Cough that produces blood Been exposed to anyone with tuberculosis.....

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

DENTAL INFORMATION

Please mark (x) your response to indicate if you have or have not had any of the following disease or problems.

Y N ?

Y N ?

Do your gums bleed when you brush or floss?

Are you currently experiencing dental pain or discomfort?.....

Are your teeth sensitive to cold, hot, sweets, or pressure?.....

Do you have earaches or neck pains?

Does food or floss catch between your teeth?.....

Do you have any clicking, popping or discomfort in the jaw?.....

Is your mouth dry?

Do you brux or grind your teeth ?

Have you had any periodontal (gum) treatments?

Do you have sores or ulcers in your mouth?.....

Have you ever had orthodontic (braces) treatment?.....

Do you wear dentures or partials?

Have you had any problems associated with previous dental treatment?.....

Do you participate in active recreational activities?

Is your home water supply fluoridated?

Have you ever had a serious injury to your head or mouth?

Do you drink bottled or filtered water?

If yes, how often? Check one: Daily Weekly Occasionally

What is the reason for your dental visit today?

How do you feel about your smile?

Date of your last dental x-ray?

Date of your last dental exam?

What was done at that time?

MM ____ / DD ____ / YYYY ____ MM ____ / DD ____ / YYYY ____

FOR COMPLETION BY DENTIST

Comments: _____

MEDICAL INFORMATION

Please mark (x) your response to indicate if you have or have not had any of the following disease or problems.

	Y N ?	Women Only	Y N ?
Do you wear contact lenses?.....		Are you pregnant?.....	
Do you use controlled substances (drugs)?.....		If yes, how many weeks are you?.....	
Do you use tobacco (smoking, snuff, chew)?.....		Are you taking birth control pills or hormonal replacement?	
Do you drink alcoholic beverages?		Are you nursing?	

Joint Replacement:

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement..... **Y N ?**

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date Treatment Began: _____

Diseases & Medical Problems: Please mark (x) your response to indicate if you have or have not had any of the following disease or problems.

Y N ?	Y N ?	Y N ?
Artificial (prosthetic) heart valve.....	Anemia.....	Ulcers.....
Previous infective endocarditis	Blood transfusion	Thyroid problems.....
Damaged valves in transplanted heart.....	If yes, date: _____	Stroke.....
Congenital heart disease (CHD).....	Hemophilia	Glaucoma.....
Unrepaired, cyanotic CHD.....	AIDS or HIV infection	Hepatitis, jaundice or liver disease
Repaired (completely) in last 6 months.....	Arthritis.....	Epilepsy
Repaired CHD with residual defects.....	Autoimmune disease	Fainting spells or seizures.....
Cardiovascular disease.....	Rheumatoid arthritis	Neurological disorders.....
Angina.....	Systemic lupus erythematosus.....	If yes, specify: _____
Arteriosclerosis	Asthma.....	Sleep disorder.....
Congestive heart failure.....	Bronchitis	Mental health disorders
Damaged heart valves	Emphysema	If yes, specify: _____
Heart attack.....	Sinus trouble.....	Recurrent Infections
Heart murmur	Tuberculosis.....	If yes, type of infection: _____
Low blood pressure	Cancer/Chemotherapy/Radiation Treatment ...	Kidney problems
High blood pressure	Chest pain upon exertion	Night sweats.....
Other congenital heart defects	Chronic pain.....	Osteoporosis.....
Mitral valve prolapse.....	Diabetes Type I or II	Persistent swollen glands in neck
Pacemaker.....	Eating disorder.....	Severe headaches/migraines.....
Rheumatic fever.....	Malnutrition.....	Severe or rapid weight loss.....
Rheumatic heart disease	Gastrointestinal disease.....	Sexually transmitted disease.....
Abnormal bleeding.....	G.E. Reflux/persistent heartburn.....	Excessive urination.....

Allergies: Please mark (x) your response to indicate if you are allergic to any of the following. For all yes responses, please specify type of reaction.

Y N ?	Y N ?
Local anesthetics.....	Latex (rubber).....
Aspirin	Iodine
Penicillin or other antibiotics.....	Hay fever/seasonal.....
Barbiturates, sedatives, or sleeping pills.....	Animals.....
Sulfa drugs	Food
Codeine or other narcotics.....	Other: _____
Metals.....	

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition, or problem not listed above that you think we should know about?

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____