MINERDENTAL

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? *MM* ______ / *DD* ______ / *YYYY* ______

Date of your last dental exam? *MM* ______ / *DD* ______ / *YYYY* ______

What was done at that time? ____________

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	?
Do you wear contact lenses?	☐	☐	☐
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew)?	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐

Women Only	Y	N	?
Are you pregnant?	☐	☐	☐
If yes, how many weeks are you?	☐	☐	☐
Are you taking birth control pills or hormonal replacement?	☐	☐	☐
Are you nursing?	☐	☐	☐

Joint Replacement:	Y	N	?
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement	☐	☐	☐

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

	Y	N	?
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	?
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐

	Y	N	?
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ______________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐

	Y	N	?
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ______________			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: ______________			
Recurrent Infections	☐	☐	☐
If yes, type of infection: ______________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
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	?
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐

	Y	N	?
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

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

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

	Y	N	?
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:** ______________