ADULT HEALTH HISTORY FORM

NAME: ______________________________

DATE: ______________________________

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 not completing this form for another person, what is your relationship to that person?

Your Name: ________ Relationship: ________

Do you have any of the following disease or problems:

Question	Y	N	?
Active Tuberculosis	☐	☐	☐
Cough that produces blood	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
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

Question	Y	N	?
Do your gums bleed when you brush or floss?	☐	☐	☐
Are you teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

If yes, how often? Circle 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

Question	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?	☐	☐	☐

Allergies: *Please indicate if you are allergic to any of the following. For all* ***yes*** *responses, please specify type of reaction.*

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

Diseases & Medical Problems: *Please indicate if you have had any of the following diseases or medical problems.*

Condition	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	☐	☐	☐
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	☐	☐	☐
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	☐	☐	☐

Question	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: ______

Question	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: ______ **Phone:** ______