Adult Health History

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.

Patient First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

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

Your Name: _____ Relationship: _____

DENTAL INFORMATION

Please mark your responses to the following questions

	Yes	No
Do your gums bleed when you brush or floss?	○	○
Are your teeth sensitive to col d, hot, sweets or pressure?	○	○
Is your mouth dry?	○	○
Have you had any periodontal (gum) treatments?	○	○
Have you ever had orthodontic (braces) treatment?	○	○
Have you had any problems a ssociated with previous denta l treatment?	○	○
Is your home water supply flu oridated?	○	○

	Yes	No
Are you currently experiencing dental pain or discomfort?	○	○
Do you have earaches or neck pains?	○	○
Do you have any clicking, pop ping or discomfort in the jaw?	○	○
Do you brux or grind your teet h?	○	○
Do you have sores or ulcers in your mouth?	○	○
Do you wear dentures or parti als?	○	○
Do you participate in active re creational activities?	○	○
Have you ever had a serious in jury to your head or mouth?	○	○

MEDICAL INFORMATION

Please mark your response to indicate if you have or have not had any of the following diseases or problems.

Are you in good health? Has there been any change in your general health within the past year?

○ Yes
○ No

○ Yes
○ No

Have you had a serious illness, operation or been hospitalized in the past 5 years?

○ Yes
○ No

If YES, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?

Medication Name:

Comments/Dosage:

Do you use controlled substances (drugs)?

○ Yes
○ No

Do you use tobacco (smoking, snuff, chew, bidis)?

○ Yes
○ No

If so, how interested are you in stopping?

Do you drink alcoholic beverages?

○ Yes
○ No

If yes, how much do you typically drink in a week?

WOMEN ONLY Are you:

If Pregnant Number of weeks:

	Yes	No
Pregnant?	○	○
Taking birth control pills or hormonal replacement?	○	○
Nursing?	○	○

Are you allergic to or have you had a reaction to any of the following:

- ☐ Amoxicillan
- ☐ Cashews
- ☐ Eggs
- ☐ Flouride
- ☐ Latex
- ☐ Local anesthetic
- ☐ Milk
- ☐ Nuts
- ☐ Other
- ☐ Peanuts
- ☐ Penicillin or other antibiotics
- ☐ Pollen Dust
- ☐ Seasonal
- ☐ Soy
- ☐ Tree Nuts

Do you have or have had any of the following diseases or medical problems:

- ☐ (TMJ) pain/jaw discomfort
- ☐ ADD / ADHD
- ☐ ADHD
- ☐ Alzheimer's or Dementia
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Anxiety/Nervousness
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Autism
- ☐ Bed Wetting
- ☐ Bleeding disorder/Hemophilia
- ☐ Blood Disease
- ☐ Cancer / tumors
- ☐ Cardiomyopathy (Heart Muscle Disease)
- ☐ Celiac disease
- ☐ Chemotherapy
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Congenital Heart Disease (CHD)
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Frequent Headaches
- ☐ Gag Reflux
- ☐ Heart Arrhythmias
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Stent
- ☐ Heart transplant
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hormone imbalance or deficiency
- ☐ Infective endocarditis
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Memory Loss/Alzheimer's Disease
- ☐ Nursing
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Other
- ☐ Pneumonia
- ☐ Pregnant/planning
- ☐ PREMEDICATION NEEDED
- ☐ Radiation therapy?
- ☐ Rheumatoid arthritis
- ☐ Sensory Disorder
- ☐ Sexually transmitted disease
- ☐ Sickle Cell Disease
- ☐ Sjögren's syndrome
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke
- ☐ Thyroid Disease

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

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

○ Yes
○ No

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:

Sign