ADULT HEALTH HISTORY

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask us. We will be happy to help.

Name: _____ I prefer to be called_____

Today's Date:____/____/____ Birthdate: ____/____/____ Home Phone Number: (____) _____

How did you hear about our practice?_____

Previous dentist's name? _____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Address: _____
City State Zip

Phone #: ( )_____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain:_____

_____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever had a blood transfusion? ❑ Yes ❑ No

Have you ever taken PhenPhen/Fosamax? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Barbiturates	Y N Jewelry	Y N Seasonal
Y N Codeine	Y N Latex	Y N Sulfa Drugs
Y N Dental Anesthetics	Y N Other_____	

Please list additional drugs that cause allergic reactions: _____

_____

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes, week #:_____ ❑ No

Are you nursing? ❑ Yes ❑ No

Are you taking any prescriptions or over-the-counter drugs? ❑ Yes ❑ No

If yes, please list each one:_____

Have you experienced the following diseases or medical conditions?

Y N Abnormal Bleeding	Y N Emphysema	Y N Liver Disease
Y N Alcohol Abuse/Drug Abuse	Y N Epilepsy/Seizures	Y N Mitral Valve Prolapse
Y N Anemia	Y N Fainting Spells	Y N Pacemaker
Y N Arthritis	Y N Frequent/Severe Headaches	Y N Persistent Cough
Y N Artificial Bones/Joints	Y N Glaucoma	Y N Psychiatric Problems
Y N Artificial Heart Valves	Y N Hay Fever	Y N Radiation Treatment
Y N Asthma	Y N Heart Attack	Y N Rheumatic Fever
Y N Blood Transfusion	Y N Heart Murmur	Y N Scarlet Fever
Y N Cancer	Y N Heart Surgery	Y N Sinus Problems
Y N Chemotherapy	Y N Hepatitis Type _____	Y N Steroid Therapy
Y N Colitis/Ulcers	Y N Herpes/Fever Blisters	Y N Stroke
Y N Congenital Heart Defect	Y N High/Low Blood Pressure	Y N Thyroid Problems
Y N Diabetes	Y N HIV+/AIDS	Y N Tuberculosis (TB)
Y N Difficulty Breathing	Y N Kidney Problems	Y N Venereal Disease

Please list any hospitalizations or major surgeries in the last five years:_____

_____

List any serious medical condition(s) that you have experienced (not listed above):_____

_____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

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