02 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:

Patient Last Name:

Date of Birth:

Pharmacy Name

Pharmacy Cross Streets and Phone Number

Emergency Contact Name:

Relationship:

Phone Number:

Do you have any of the following diseases or problems:

	Yes	No
Active Tuberculosis	○	○
Persistent cough greater than a 3 week duration	○	○
Cough that produces blood	○	○
Been exposed to anyone with tuberculosis	○	○

MEDICAL INFORMATION

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

Are you now under the care of a physician?

○ Yes
○ No

Physician Name:

Phone#:

Address/City/State/Zip:

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

○ Yes
○ No

Date of last physical exam:

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?

Medications

Medication Name:

Comments/Dosage:

Medications: Please list any other medications you are currently taking.

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?

○ Yes
○ No

Date Treatment began:

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?

If yes, how much alcohol did you drink in the last 24 hours?

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

WOMEN ONLY Are you:

If Pregnant how many weeks:

○ Yes
○ No

	Yes	No
Pregnant?	○	○
Taking birth control pills	○	○
Nursing?	○	○

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

- ☐ Amoxicillan
- ☐ Antihistamine
- ☐ ASPIRIN
- ☐ Bacitracin
- ☐ Betadine
- ☐ Biaxin
- ☐ Clindamycin
- ☐ CODEINE
- ☐ ERYTHRO
- ☐ FLUORIDE
- ☐ HAY FEVER
- ☐ Iodine
- ☐ Keflex
- ☐ LATEX
- ☐ Liidocaine
- ☐ MORPHINE
- ☐ Mupirocin
- ☐ Omeprazole
- ☐ OXYCODONE
- ☐ PENICILLIN
- ☐ PERCOCET
- ☐ pollen
- ☐ seasonal
- ☐ SULFA

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

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ A-Fib
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Condition
- ☐ Heart Disease
- ☐ Heart Implant
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Inflammation of the joint
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ lichen planus
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ No Epi
- ☐ Osteoporosis
- ☐ Other
- ☐ Pacemaker
- ☐ Pain
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal 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

Name of physician or dentist making recommendation:

Phone#:

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