ADULT HEALTH HISTORY FORM

First Name: Last Name: MI: Date:

Date of Birth: Phone: ( ) Sex: ☐ M ☐ F

Street/Box: City: Zip:

Are you currently seeing a physician now? ☐ Yes ☐ No If so, why?

Physician's Name: Date of Last Physical Examination: / /

Allergies: Please Circle Amoxicillin Aspirin Erythromycin Latex Sulfa Others_____

Anesthetics Codeine Metals/Jewelry Penicillin Tetracycline

Describe Symptoms to allergies: _____

For the following questions, please (x) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note 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 clinic does not use this information to discriminate.

Do you have any of the following conditions? **CHECK YES, NO, or UNSURE** **PLEASE MAKE SURE THAT EVERY BOX IS CHECKED**

MEDICAL INFORMATION

	YES	NO	Unsure		YES	NO	Unsure
Acid Reflux	☐	☐	☐	**Heart Murmur**	☐	☐	☐
Alzheimer's/Memory Loss	☐	☐	☐	**Hemophilia/Abnormal Bleeding**	☐	☐	☐
Anemia	☐	☐	☐	**Hepatitis A B C D**	☐	☐	☐
Anorexia/Bulimia	☐	☐	☐	**High/Low Blood Pressure**	☐	☐	☐
Arthritis	☐	☐	☐	**HIV/AIDS**	☐	☐	☐
Asthma/Hay Fever	☐	☐	☐	**Kidney Problems**	☐	☐	☐
Blood Transfusions	☐	☐	☐	**Liver Disease**	☐	☐	☐
Cancer/Chemotherapy	☐	☐	☐	**Mental Illness type_____**	☐	☐	☐
Cold Sores/Herpes	☐	☐	☐	**Mitral Valve Prolapse**	☐	☐	☐
Congenital Heart Defect	☐	☐	☐	**Pacemaker**	☐	☐	☐
Diabetes	☐	☐	☐	**Radiation**	☐	☐	☐
Difficulty Breathing	☐	☐	☐	**Rheumatic/Scarlet Fever**	☐	☐	☐
Drug/ Alcohol Abuse	☐	☐	☐	**Shingles**	☐	☐	☐
Emphysema	☐	☐	☐	**Sinus Problems**	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	**Smoking/Tobacco**	☐	☐	☐
Fainting	☐	☐	☐	**Snoring/Sleep Apnea**	☐	☐	☐
Gastrointestinal Disorder	☐	☐	☐	**Stroke**	☐	☐	☐
Glaucoma	☐	☐	☐	**Tuberculosis**	☐	☐	☐
Headaches/Migraines	☐	☐	☐	**Tumor/Growth**	☐	☐	☐
Hearing Impaired	☐	☐	☐	**Venereal Disease**	☐	☐	☐
Heart Attack/Heart Surgery	☐	☐	☐	**Osteoporosis**	☐	☐	☐
Other Surgeries? List_____ _____	☐	☐	☐	**Have you ever taken medication for Osteoporosis?**	☐	☐	☐

Premeds and Pregnancy Information

Premeds:

Do you have any of the following: Please Circle Artificial Joints, Pins, Screws, Plates, Heart Valves, or Shunts

If yes, what is the date of the procedure or condition ___/_____/_____

Have you ever been told you need antibiotics/premedication prior to dental appointment for the circled condition above **YES / NO**

Pregnancy:

Are you currently pregnant **YES / NO**

Due Date ___/____/_____ Are you currently Nursing **YES / NO**

Current Medication List

Are you taking any prescription medications, over the counter medications, vitamins, natural and/or herbal dietary supplements? Yes_____ No_____

Please List All Medications:	Reason Taking:	How Much:	How Often:
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

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. 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

With a return visit, a patient signature is required to indicate the health history has been reviewed and any changes have been made after the original date on the health history.

_____ _____
Signature of Patient / Legal Guardian Date

_____ _____
Signature of Patient / Legal Guardian Date

_____ _____
Signature of Patient / Legal Guardian Date

FOR OFFICE USE ONLY

_____ _____
Signature of Dentist / Hygienist. Also student if applicable Date

_____ _____
Signature of Dentist / Hygienist. Also student if applicable Date

_____ _____
Signature of Dentist / Hygienist. Also student if applicable Date