

**Dental Department Adult Health History**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_

Medical Doctor (Name, address, phone number): \_\_\_\_\_

Date of last physical: \_\_\_\_\_

Please list any medications (prescription or over the counter), vitamins, or supplements you are taking:

Please list all allergies and reactions:

Have you been hospitalized for care or surgery? If yes, list reasons:

Have you been treated for cancer, had chemotherapy, or had radiation treatment? If yes, list type and reason:

Have you ever been told you need antibiotic premedication before dental appointments?... Yes  No

Have you ever taken any bisphosphonates or medication for osteoporosis?..... Yes  No

Have you ever had any serious complications with dental treatment? .....Yes  No

**DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING CONDITIONS? Check YES, NO, DON'T KNOW**

	YES	NO	DK		YES	NO	DK
Headaches/Migraines .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pace Maker .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acid reflux .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	DK		YES	NO	DK
Rheumatoid Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Addiction/Recreational Drug Use ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Muscular Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

**Women**

Are you pregnant? .....  YES  NO  DK Due date? \_\_\_\_\_

Are you nursing? .....  YES  NO  DK

Please list any disease, condition, or problem not listed above:

**Dental History**

Who was your previous dentist? \_\_\_\_\_

When was your last dental exam and xrays? \_\_\_\_\_

When was your last cleaning? \_\_\_\_\_

What is the reason for your dental visit today?

**Check YES, NO, DON'T KNOW.**

	YES	NO	DK		YES	NO	DK
Do your gums bleed? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interested in getting dentures? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have loose teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had braces? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your gums swollen or tender? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any gum surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Complications after extractions? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems with local anesthesia? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or missing information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist/Hygienist Signature

\_\_\_\_\_  
Date