Adult Health History Form

Patient Name _____Birth Date_____ Today's Date_____

Please answer the following questions. 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.

Allergies: Circle all that apply **None**

Amoxicillin
Aspirin
Anesthetics
Codeine
Erythromycin
Latex
Metals/Jewelry
Penicillin
Sulfa
Tetracycline
Other_____

(WOMEN) Are you pregnant? **YES/NO** Due date__/__/__ Nursing? **YES/NO** Taking birth control? **YES/NO**

Do you need a **premedication (antibiotic)** prior to dental work for reasons such as; **artificial joints, pins, screw, plates, heart valves, shunts**? **YES/NO** If yes, Date __/__/__

Are you currently take a blood thinner such as **Coumadin** or **Warfarin**? **YES/No**

Do you have any of the following conditions? Please check ☑ YES or ☑ NO

	YES	NO		YES	NO
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 OR Liver Disease	☐	☐
Blood Transfusions	☐	☐	Mental Illness type_____	☐	☐
Cancer/Chemotherapy	☐	☐	Mitral Valve Prolapse	☐	☐
Cold Sores/Herpes	☐	☐	Pacemaker	☐	☐
Congenital Heart Defect	☐	☐	Radiation	☐	☐
Diabetes	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Difficulty Breathing	☐	☐	Shingles	☐	☐
Drug/ Alcohol Abuse	☐	☐	Sinus Problems	☐	☐
Emphysema	☐	☐	Smoking/Tobacco	☐	☐
Epilepsy/Seizures	☐	☐	Snoring/Sleep Apnea	☐	☐
Fainting	☐	☐	Stroke	☐	☐
Gastrointestinal Disorder	☐	☐	Tuberculosis	☐	☐
Headaches/Migraines	☐	☐	Tumor/Growth	☐	☐
Hearing Impaired	☐	☐	Venereal Disease	☐	☐
Heart Attack/Heart Surgery	☐	☐	Osteoporosis / Have taken Medication for Osteoporosis	☐	☐

OVER ➔

Primary Physician's Name_____ ☎ Number_____

Have you had any serious illnesses or surgeries? **YES/NO** If yes, describe_____

_____

Current list of Medications	Reason Taking	How Much	How Often

Please 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_____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 Signature of Patient / Legal Guardian/Date

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FOR OFFICE USE ONLY

_____/_____ _____/_____

Signature of Dentist / Hygienist/Student Signature of Dentist / Hygienist/Student

_____/_____ _____/_____