Adult Patient Health History

Patient's Name: _____ Date of Birth: _____

Address: _____ Home Ph: _____ Cell: _____

We confirm appointments electronically by email. Please provide your email so we may send appointment reminders.

Email: _____ @ _____

DENTAL HISTORY

Check (√) if you have had any of the following:

☐ bad breath	☐ clicking or popping jaw	☐ periodontal treatment	☐sensitivity to hot/cold
☐ bleeding gums	☐ grinding teeth	☐ sores/growths in the mouth	☐ sensitivity to sweets
☐ broken fillings	☐ loose teeth	☐ pain when biting/chewing	☐ difficulty flossing

☐ other *(please explain)* : _____

New Patients Only

Name of former dentist: _____ Date of last dental exam: _____

Address: _____ Date of last dental x-rays: _____

MEDICAL HISTORY

Physician's Name/Location: _____ Date of last visit: _____

Have you ever had any serious illnesses or operations? ☐ No ☐ Yes *(please explain)* _____

Have you taken any of the group of drugs collectively referred to as *fen-phen* ? ☐ Yes☐ No

Women only

Are you pregnant? ☐ No ☐ Yes *due date:* _____ Are you nursing? ☐ Yes ☐ No

Check (☆) all that apply:

☐ alcohol abuse	☐ anemia	☐ glaucoma	☐ shortness of breath
☐ artificial heart valve	☐ arthritis/rheumatism	☐ headaches	☐ slow healing wounds
☐ artificial joints	☐ asthma	☐ heart disease	☐ stomach/digestive problems
☐ bleeding disorder	☐ birth control pills	☐ hemophilia	☐ stroke
☐ chemotherapy	☐ cancer	☐ herpes	☐ swollen feet/ankles
☐ ***coumadin or warfarin***	☐ chronic sinusitis	☐ high cholesterol	☐ thyroid condition
☐ drug abuse	☐ circulatory problems	☐ high blood pressure	☐ tobacco use
☐ heart murmur	☐ cortisone treatment	☐ jaw pain	☐ tonsilitis
☐ hepatitis	☐ cough (persistent)	☐ kidney disease	☐ tumors/growths
☐ HIV/AIDS	☐ coughing up blood	☐ liver disease	☐ ulcers - gastric
☐ mitral valve prolapse	☐ diabetes	☐ osteoporosis medication	☐ venereal disease
☐ ***need premedication***	☐ epilepsy / seizures	☐ radiation treatment	☐ other _____
☐ pacemaker	☐ fainting	☐ COPD/respiratory	☐ other _____
☐ tuberculosis	☐ GERD	☐ scarlet or rheumatic fever	☐ other _____

ALLERGIES

☐ *NONE*

☐ aspirin	☐ local anesthetic	☐ penicillin
☐ codeine	☐ **LATEX**	☐ sulfa

☐ other: _____

☐ other: _____

MEDICATIONS

*List **ALL** medications and supplements you are taking.*
Use other side if necessary.

_____

_____

_____

I certify that the above information is complete and correct. I will not hold my dentist of any member of his staff responsible for any action they take or do not take because of errors or omissions I may have made on this form.

Patient signature: _____ Date: _____

STAFF USE ONLY

☐ COUMADIN	☐ No EPI	HX taken by: _____
☐ **LATEX ALLERGY**	☐ See med list	☐ Chart Flagged
☐ PRE MED	☐ Other _____	☐ Dentrix

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