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
☐ artificial heart valve
☐ artificial joints
☐ bleeding disorder
☐ chemotherapy
☐ ***coumadin or warfarin***
☐ drug abuse
☐ heart murmur
☐ hepatitis
☐ HIV/AIDS
☐ mitral valve prolapse
☐ ***need premedication***
☐ pacemaker
☐ tuberculosis
☐ anemia
☐ arthritis/rheumatism
☐ asthma
☐ birth control pills
☐ cancer
☐ chronic sinusitis
☐ circulatory problems
☐ cortisone treatment
☐ cough (persistent)
☐ coughing up blood
☐ diabetes
☐ epilepsy / seizures
☐ fainting
☐ GERD
☐ glaucoma
☐ headaches
☐ heart disease
☐ hemophilia
☐ herpes
☐ high cholesterol
☐ high blood pressure
☐ jaw pain
☐ kidney disease
☐ liver disease
☐ osteoporosis medication
☐ radiation treatment
☐ COPD/respiratory
☐ scarlet or rheumatic fever
☐ shortness of breath
☐ slow healing wounds
☐ stomach/digestive problems
☐ stroke
☐ swollen feet/ankles
☐ thyroid condition
☐ tobacco use
☐ tonsilitis
☐ tumors/growths
☐ ulcers - gastric
☐ venereal disease
☐ other _____
☐ other _____
☐ 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 *rev 4/16*