

ADULT HEALTH HISTORY
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Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Date of last medical exam: _____

List any medications you are taking currently, including vitamins, herbs, OTC, birth control pills: _____

Are you allergic to, or have you reacted adversely to, any of the following:

Aspirin:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Codeine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Penicillin:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Erythromycin:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Latex:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Local Anesthetic:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nitrous Oxide:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Other (please describe): _____

Are you allergic to any foods? Yes No

If yes, please list: _____

Are you in good health? Yes No

Has there been any change in your health in the past year? Yes No

Are you under the care of a Physician? Yes No

If yes, for what condition(s)? _____

Physician's name: _____ Specialty: _____

Have you had any serious illness, operation or been hospitalized in the past 5 years? Yes No

If yes, for what condition(s)? _____

Do you smoke? Yes No

If yes, # of Packs per day: _____ For how many years: _____

Do you have a history of alcohol abuse and/or drug use? Yes No

If yes, please explain: _____

Are you using any recreational drugs?

If yes, please list _____

Has your physician ever told you to take antibiotics prior to dental visits? Yes No

Have you ever had complications following dental treatment? Yes No

PLEASE CONTINUE ON PAGE TWO

Name: _____

Date of Birth: _____

Do you have, or have you had, any of the following disease or problems? Please check all that apply.

- | | | | |
|-----------------------------|--|------------------------------|--|
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial heart valve(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial joints or grafts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Painful joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Persistent diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic heartburn | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Compromised immune system | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent weight loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital heart defect | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coronary disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually transmitted disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe "gag" reflex | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Frequent urination | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gastric reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay fever/allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | TMJ disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Are you taking Bisphosphonates (e.g., Fosamax, Boniva) currently? Yes No

Have you ever taken Bisphosphonates? Yes No

If yes, when did you stop taking them: _____

Women: Are you currently pregnant? Yes No

If yes, what is your due date: _____

Are you nursing? Yes No

Is there any possibility that you might be pregnant? Yes No

I understand that withholding any information about my health could seriously jeopardize my safety. I have reviewed this health history form carefully and have answered all questions truthfully to the best of my knowledge. I will inform the doctors of any changes in my health.

Signature of Patient or Legally Authorized Representative

Date

Printed Name of Patient or Representative

Relationship to Patient