Adult Health History

Confidential Health Questionnaire

Patient's Name_____ Patient's Birthdate_____ Age_____ Social Security Number_____

Patient's Home Address_____ Apt._____ PO Box_____ City_____ State_____ Zip_____

Home Telephone Number_____ Cell Phone Number_____ E-mail Address_____

Employer's Name_____ Work Telephone Number_____

Employer's Address_____ City_____ State_____ Zip_____

Spouse's Name_____ Spouse's Birthdate_____ Spouse's Social Security Number_____

Spouse's Cell Phone Number_____ Spouse's E-mail Address_____

Spouse's Employer's Name_____ Spouse's Work Telephone Number_____

Spouse's Employer's Address_____ City_____ State_____ Zip_____

Dental Insurance_____ Carrier of Plan – Subscriber_____ SS# of Subscriber_____

Group Number or Plan ID Number_____ Effective Date_____

Secondary Dental Insurance_____ Carrier of Plan – Subscriber_____ SS# of Subscriber_____

Group Number or Plan ID Number_____ Effective Date_____

Physician's Name_____ Telephone Number_____ City_____ State_____

Referred to our office by:_____

MEDICAL HISTORY

	Yes	No
1. Are you being treated for any condition by a physician now? If yes, what is the condition?	○	○
2. When was your last physical examination?	○	○
3. Has there been any change in your health in the last year?	○	○
4. Are you taking any medications? If yes, please list them.	○	○
5. Have you ever experienced a bad reaction with dental anesthetic?	○	○
6. Have you ever had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or your lips?	○	○
7. Have you ever been hospitalized? If yes, please explain.	○	○
8. Have you ever had a major operation? If yes, please explain.	○	○
9. Have you ever taken any diet or weight control medications? If yes, what?	○	○

10. Have you ever had any of the following?

__Damaged Heart Valve
__Artificial Heart Valve
__Cardiac Pacemaker
__Artificial Joint Replacement
__Pin Placed in the Bone
__Stroke
__Congenital Heart Lesion
__Injury to Face or Jaw
__High or Low Blood Pressure
__Blood Transfusion
__Bleeding Problem
__Blood Disorder such as Anemia
__Ulcers or Stomach Problem
__Allergy (Hives or Skin Rash)
__Convulsions or Epilepsy
__Arthritis
__Inflammatory Rheumatism
__Glaucoma
__Diabetes (Sugar Disease)
__Kidney or Bladder Trouble
__Hepatitis or Liver Trouble
__Jaundice (Yellow Skin and Eyes)
__Tuberculosis
__Venereal Disease
__Lung Trouble
__Radiation Therapy
__Asthma
__Hay Fever and Sinus Problems
__Frequent, Severe Headaches
__Cortisone, Hydrocortisone (ACTH)
__Thyroid Problems
__Malignancies
__Eating Disorder
__Heart Disease
__Heart Attack
__Mitro Valve Prolapse
__Heart Murmur
__HIV

If you have any disease, condition or problem not listed above that you think I should know about, please explain.

	Yes	No
11. Have you ever experienced a bad reaction to any of the following drugs?		
___Aspirin	○	○
___Penicillin	○	○
___Iodine	○	○
___Sulfonamides, Sulfa	○	○
___Barbiturates, Sleeping Pills	○	○
___Codeine	○	○
Tetracycline	○	○
___Clindamycin	○	○

If there are any others that are not listed above, please list.

_____

_____

12. Do you have a history of allergies to any other substance (latex, environmental, etc.)?	○	○

_____

13. Are you taking any herbal supplements?	○	○

_____

14. Do you have any chest pain on exertion?	○	○
15. Is there a history of Diabetes in your family? With whom?	○	○

_____

16. Do you have a tendency to faint?	○	○
17. Are you pregnant?	○	○
18. Are you nursing?	○	○
19. Are you taking birth control pills?	○	○

DENTAL HISTORY

20. Are you dissatisfied with the appearance of your teeth?	○	○
21. Are you worried about receiving dental treatment?	○	○
22. Do you have difficulty chewing your food?	○	○
23. Are your teeth sensitive to cold, heat or sweets?	○	○
24. Have you had a toothache recently?	○	○
25. Do you have bleeding gums? When and where?	○	○

_____

26. Do you have frequent canker sores or cold sores?	○	○
27. Have you noticed any bad odors or tastes from your mouth?	○	○
28. Have you ever had Vincent's infection or trench mouth?	○	○
29. Is it difficult for you to open your mouth as wide as you would like?	○	○
30. Does your jaw click when you chew?	○	○
31. Do you ever have pain in the region in front of your ears?	○	○
32. Have you ever worn a bite splint or guard?	○	○
33. Do you clench or grind your teeth?	○	○

	Yes	No
34. Do you have any habits such as biting your nails, chewing on a pen or pencil, etc.? If yes, please explain.	○	○

_____

_____

35. Have you been under more than average stress or tension?	○	○

36. When did you last have your teeth cleaned?

_____

37. How frequently have you had your teeth cleaned in the last 10 years?

_____

38. Have you ever had orthodontic treatment?	○	○
39. Have you ever had periodontal, gum, treatment?	○	○

40. Approximate date of last tooth extraction.

_____

___Why?_____

41. Have you ever had endodontic, root canal, treatment?	○	○
42. Have any of your teeth recently separated creating space between them?	○	○
43. Does food wedge between any of your teeth?	○	○
44. Do you wear a removable bridge and/or denture? How many years?_____ Is it worn at night?_____ Is it comfortable?	○	○

_____

45. Have you noticed any loose teeth? Where?	○	○

_____

46. How often do you brush your teeth? _____times per day. When?

_____

47. Do you use dental floss, rubber tips or stimudents daily? Which?	○	○

_____

48. Do you smoke? What and how much?	○	○

_____

49. Would you be greatly disturbed if you had to lose all your natural teeth and wear false teeth?	○	○
50. To your knowledge, is there any history of periodontal (gum) disease in your family?	○	○

51. Please add any information you feel is important. ___

_____

_____

Patient's Signature:_____ Date:_____

Patient's Signature:_____ Date:_____

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