DENTAL HEALTH CARE CENTER

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Adult Health History

Patient Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you answered no to all the COVID-19 screening questions asked to you when you arrived today? * ◯ Yes ◯ No

When did you last see a physician?
*

____

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Have you been hospitalized or had a major operation in the past 5 years?
* ◯ Yes ◯ No

If yes, please explain:

____

____

Are you being treated for Diabetes? * ◯ Yes ◯ No

If yes, what is your most recent A1c reading? ______________________

Are you currently taking a blood thinner?
* ◯ Yes ◯ No

If yes, what is your most recent INR reading? ______________________

Please list the medications you are currently taking:

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Please check the conditions that apply to you:

☐ Heart Trouble	☐ Anemia	☐ Fainting Spells	☐ Heart Attack	☐ Sickle Cell Disease
☐ Tuberculosis	☐ Mitral Valve Prolapse	☐ Blood Transfusion	☐ Glaucoma	☐ Artificial Heart Valve
☐ Hepatitis C	☐ HIV+/AIDS	☐ Congenital Heart Defect	☐ Hepatitis Any Type	☐ Arthritis
☐ Heart Surgery	☐ Cancer (Past/Current)	☐ Cosmetic Surgery	☐ Pacemaker	☐ Liver Disease
☐ Osteoporosis	☐ High Blood Pressure	☐ Thyroid Problems	☐ Anxiety	☐ Low Blood Pressure
☐ Difficulty Breathing	☐ Kidney Problems	☐ High Cholesterol	☐ Asthma	☐ Venereal Disease
☐ Stroke	☐ Sinus Problems	☐ Drug Abuse	☐ Antibiotic Pre-Med	☐ Ulcers/Acid Reflux
☐ Alcohol Abuse	☐ Rheumatic Fever	☐ Diabetes	☐ Tobacco Use	☐ Electronic Cigarette Use
☐ Abnormal Bleeding	☐ Epilepsy	☐ Depression	☐ Hemophilia	☐ Seizures
☐ Sleep Apnea/ CPAP	☐ Aspirin/Blood thinners	☐ Herbal Supplements	☐ OTC Vitamins	☐ Shingles
☐ Memory Loss/Dementia				

Notes on any conditions above:

Are you allergic or have had a negative reaction to any of the following:

☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Sulfa Drugs ☐ Latex ☐ Metals ☐ Other

Notes:

Are you currently, or have you in the past, ever taken intravenous or oral bisphosphonate medications, i.e. Boniva, Fosamax, etc? *

◯ Yes ◯ No

If yes, please list medication name and dosage:

Have you ever had a joint replacement? * ◯ Yes ◯ No

If yes, what was the date of your procedure?

Has it ever been recommended for you to take antibiotic pre-medication before dental appointments? * ◯ Yes ◯ No

If yes, for what reason? Please provide antibiotic name, dosage and protocol of how you have been directed to take the pre-medication before appointment below:

Are you up to date on your vaccinations? * ◯ Yes ◯ No

If NO, please explain:

If female, are you currently

☐ Nursing ☐ Taking contraceptives ☐ Pregnant/trying to get pregnant

Is there any disease, condition, or problem that you think this office should know about that has not been covered? * ◯ Yes ◯ No

If yes, please descibe below:

Physician AND Pharmacy Name and Phone Number:

Signature ____ **Date** ____________

Response Date: ____/____/________