

# DENTAL HEALTH CARE CENTER

www.dentalhealthcarecenter.com

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1717 EAST 66TH STREET • Richfield, MN 55423

(612)861-7109

## 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.

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?

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Yes  No

If yes, please explain:

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Are you being treated for Diabetes? \*  Yes  No

If yes, what is your most recent A1c reading? \_\_\_\_\_

Are you currently taking a blood thinner?

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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:

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

Notes on any conditions above:

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

Penicillin     Aspirin     Codeine     Sulfa Drugs     Latex     Metals     Other

Notes:

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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:

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

If yes, what was the date of your procedure?

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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:

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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 describe below:

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Physician AND Pharmacy Name and Phone Number:

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Signature \_\_\_\_\_ Date \_\_\_\_\_

Response Date: \_\_\_\_\_