DENTAL HEALTH CARE CENTER

www.dentalhealthcarecenter.com | appointments@dentalhealthcarecenter.com
1717 E 66TH ST • 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, may have a critical interrelationship with the dentistry you will receive. Thank you for answering the following questions.

When did you last see your MEDICAL primary care physician? ____________________

In the past 5 years, have you been hospitalized or had a major operation? ◯ Yes ◯ No

If yes, please explain:

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Are you being treated for Diabetes? *

☐ Type I ☐ Type II ☐ Pre-Diabetic ☐ No

If yes, what is your most recent A1C reading? ____________________

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

If taking Warfarin or Coumadin, what is your most recent INR reading? ____________________

If female, are you currently

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

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Please check the conditions that apply to you, including the conditions that are being treated with medication:

☐ Abnormal Bleeding	☐ Depression	☐ Liver Disease	☐ Anemia
☐ Difficulty Breathing	☐ Low Blood Pressure	☐ Angina (Chest Pain)	☐ Epilepsy/ Seizures
☐ Memory Loss/ Dementia	☐ Anxiety	☐ Endocrine Disorder	☐ Mitral Valve Prolapse
☐ Artificial Heart Valve/ Stent	☐ Fainting Spells	☐ Neuropathy	☐ Arthritis
☐ Glaucoma	☐ Osteoporosis	☐ Atrial Fibrillation (A-Fib)	☐ Heart Attack
☐ OTC Vitamins	☐ Aspirin/ Blood Thinners	☐ Heart Surgery	☐ Pacemaker
☐ Asthma	☐ Heart Trouble	☐ Shingles	☐ Bleeding Disorder
☐ Hepatitis - A/ B	☐ Sinus Problems	☐ Blood Disorder	☐ Hepatitis - C
☐ Sleep Apnea (CPAP/ BiPAP)	☐ Blood Transfusion	☐ Herbal Supplements	☐ Stroke
☐ Cancer (Past/ Current)	☐ High Blood Pressure	☐ Substance Abuse/ Dependency	☐ Cold Sores/ Fever Blisters
☐ High Cholesterol	☐ Thyroid Problems	☐ Congenital Heart Defect	☐ HIV/ AIDS
☐ Tuberculosis (TB)	☐ Cosmetic Surgery	☐ Hormone Deficiency	☐ Ulcers/ Acid Reflux
☐ Cortisone Treatment	☐ Kidney Disease	☐ Venereal Disease	

Notes on any conditions above:

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Please list the all the prescription medications, over the counter vitamins and supplements you are currently taking:

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

☐ Penicillin/Amoxicillin ☐ 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, dosage, and when taken:

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:

Do you use any tobacco products? (e-cigarette, chewing, etc.) * ◯ Yes ◯ No

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:

Signature ______________________________ **Date** __________

Response Date: __________