PATIENT NAME:_____
BIRTH DATE:_____
CHART NUMBER:_____

ADULT MEDICAL-DENTAL HEALTH HISTORY QUESTIONNAIRE

DATE:_____

DIRECTIONS TO THE PATIENT: The following information about your health history is very important for us to provide you with the best possible dental care in a safe way. Incorrect information may be dangerous to your health. **ALL** questions must be answered completely and accurately. If you don't understand a question, or are unsure of the answer, or want to discuss it with the dentist, circle its number or letter, This Health History Questionnaire will become a part of the patient's dental record and will be considered confidential information.

Name of Your Physician:_____ Office Telephone:_____

Address of Your Physician_____

1. Are you in good health? ..... Yes No Don't Know

2. Has there been any change in your health in the last year? ...…..... Yes No Don't Know
   If yes, explain:_____

3. Have you ever been hospitalized, had a major operation or serious illness? ..... Yes No Don't Know
   If yes, explain: _____

4. Date of your last visit to the doctor:_____ Reason for last visit:_____

5. Are you currently receiving treatment or regular medical care by your doctor? ……. Yes No Don't Know
   If yes, for what condition(s)? _____
   _____

6. Are you taking any of the following medications:
   a. Antibiotics or sulfa drugs ……. Yes No Don't Know
   b. Anticoagulant (blood thinners) ……. Yes No Don't Know
   c. Medication for high blood pressure …….. Yes No Don't Know
   d. Cortisone (steroids) …….. Yes No Don't Know
   e. Tranquilizers ……. Yes No Don't Know
   f. Antihistamines ……... Yes No Don't Know
   g. Aspirin, Advil, Nuprin, Motrin or Naprosyn…….. Yes No Don't Know
   h. Insulin, tolbutamide (Orinase) or other drugs for diabetes ……... Yes No Don't Know
   i. Digitalis, Nitroglycerin or other drugs for heart trouble ……. Yes No Don't Know
   j. Birth control pills or other hormones …… Yes No Don't Know
   k. Synthroid or other thyroid medication …… Yes No Don't Know
   l. AZT or other drugs for HIV ……. Yes No Don't Know
   m. Bisphosphanates, Fosamax, Actonel, Boniva, Zometa, Aredia (current or past) …. Yes No Don't Know

   n. Others, including vitamins, herbs, etc please list:_____

7. Have you had any allergic or unusual reactions to any substance or medication? ….. Yes No Don't Know
   If yes, specify what substance/medications, and what reactions_____

HAVE YOU EVER BEEN TREATED BY A DOCTOR FOR: *(Circle your response and underline any condition(s))*

8. Damaged heart valves, artificial heart valves, heart murmur, rheumatic fever, rheumatic heart disease, congenital heart problem?…… Yes No Don't Know
9. Do you have an artificial joint?…….. Yes No Don't Know
10. Heart trouble, heart attack, high blood pressure, stroke? ……..Yes No Don't Know
    a. Do you have pain in your chest upon exertion?…… Yes No Don't Know
11. Severe or frequent headaches? Sinus Problems? ……Yes No Don't Know
12. Blood disorders such as anemia or hemophilia? ……. Yes No Don't Know
13. Breathing problems, emphysema, tuberculosis or other lung problems? …… Yes No Don't Know
14. Asthma, hay fever or hives? ……..Yes No Don't Know
15. Stomach or intestinal ulcers? …… Yes No Don't Know
16. Cancer, x-ray treatments, or chemotherapy? ……... Yes No Don't Know
17. Thyroid trouble? …….. Yes No Don't Know
18. Diabetes or blood sugar problems? ……. Yes No Don't Know
19. Hepatitis, jaundice, or liver disease? …….. Yes No Don't Know
20. Kidney infections, frequent urination, or renal (kidney) dialysis? ……. Yes No Don't Know
21. Stroke, seizures, fainting spells numbness or other neurological problems? ……. Yes No Don't Know
22. Syphilis, gonorrhea, or genital herpes, sexually transmitted disease? ……Yes No Don't Know
23. AIDS, AIDS-related condition or HIV positive? ……Yes No Don't Know
24. Arthritis, rheumatism, autoimmune diseases (ex. lupus)?……. Yes No Don't Know
25. Phobias, anxieties, depression, psychoses, fears, or other mental problems? ……. Yes No Don't Know
26. For **women**, are you pregnant or do you think you may be pregnant? ……Yes No Don't Know
27. Are there any other problems about your health that you know of? …… Yes No Don't Know
    If yes, describe: _____

HABITS AND PERSONAL HISTORY:

28. Do you now or have you ever used recreational drugs (besides alcohol or tobacco)? … Yes No
29. How many packs of cigarettes do you smoke per day? How many years? ……..…. ____Packs/Day ____# Yrs
    a. If you smoked in the **past** how many packs per day did you smoke? How many years? ____Packs/Day ____# Yrs
    b. If you smoked in the **past** when did you quit? ……. ____Yrs ago
    c. If you smoke, are you interested in help quitting?…… Yes No
30. How many drinks of beer, wine or liquor do you have per day? ……. ____Drinks per Day

CURRENT DENTAL CONCERNS:

31. What is your major dental concern? _____

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give my permission to the dentist to obtain from my physician or dentist, any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM: Signature:_____ Date:_____

If other than patient, indicate relationship:_____

Do not write below this line

MEDICAL HISTORY REVIEW

SIGNATURE, ATTENDING DENTIST:_____DMD, MS Date:_____