Adult Health History

Today's Date _____

Name _____ Birthdate _____

Please indicate any of the following conditions you have had or are currently having:

☐ Heart Failure	☐ Stroke	☐ Arthritis	☐ Alcohol/Drug Addiction
☐ Heart Disease/Attack	☐ Kidney Trouble	☐ Rheumatism	☐ Hemophilia
☐ Angina Pectoris	☐ Ulcers	☐ Cortisone Medicine	☐ Venereal Disease
☐ High Blood Pressure	☐ Acid Reflux	☐ Glaucoma	☐ Cold Sores/Fever Blisters
☐ Heart Murmur	☐ Cosmetic Surgery	☐ Pain in Jaw Joints	☐ AIDS/HIV
☐ Rheumatic Fever	☐ Emphysema	☐ Hepatitis A (infectious)	☐ Epilepsy or Seizures
☐ Congenital Heart Disease	☐ Chronic Cough	☐ Hepatitis B (serum)	☐ Fainting or Dizzy Spells
☐ Scarlet Fever	☐ Tuberculosis (TB)	☐ Hepatitis C	☐ Psychiatric Treatment
☐ Artificial Heart Valve	☐ Asthma	☐ Liver Disease	☐ Depression
☐ Heart Pacemaker	☐ Sinus Trouble	☐ Yellow Jaundice	☐ Bruise Easily
☐ Heart Surgery	☐ Allergies	☐ Blood Transfusion	☐ Cancer
☐ Artificial Joints (i.e. hip)	☐ Diabetes	☐ Radiation Therapy	☐ Chemotherapy
☐ Anemia	☐ Thyroid Disease	☐ Headaches	☐ Sleep Apnea

Please indicate any of the following you are allergic to or have had adverse reactions to:

☐ Latex	☐ Aspirin	☐ Nitrous Oxide	☐ Percodan
☐ Darvon	☐ Ibuprofen	☐ Penicillin	☐ Tetracycline
☐ Codeine	☐ Demerol	☐ Erythromycin	☐ Valium
☐ Local Anesthetic (Novacaine, Epinephrine)			☐ Dental Materials (please list below)

Are you aware of being allergic to any other medications, foods, or substances? ◯ Yes ◯ No

If yes, please list: _____

How likely are you to doze off or fall asleep in the following situations? Use the following scale to rate each situation: **0 = no chance of dozing, 1 = slight chance, 2 = moderate chance, 3 = high chance**

Sitting and reading 0

Watching TV 0

Sitting inactive in a public place 0

Sitting and talking to someone 0

Lying down to rest in the afternoon 0

In a car, while stopped for a few minutes in traffic 0

As a passenger in a car for an hour 0

Total Score 0

Sitting quietly after lunch (without alcohol) 0

Please add your score together and insert above

Have you been a patient in the hospital during the past two years? ◯ Yes ◯ No

Have you been under the care of a medical doctor during the past two years? ◯ Yes ◯ No

If yes: Name _____ Phone Number _____

When was your last physical exam? _____

Have you taken any medication or drugs in the past two years? ◯ Yes ◯ No

Please list any medications, drugs, vitamins, herbs, or other supplements you are currently taking:

_____

Please list any whitening or mouthwash products you currently use _____

Please indicate any of the following conditions you experience:

- ☐ When walking up stairs, have to stop because of chest pain
- ☐ Have trouble breathing when you lay flat
- ☐ Gained or lost more than 10 lbs. unexplainably in the past year
- ☐ Not feeling well rested when you awaken
- ☐ Ankles swell during the day
- ☐ Wake up choking or short of breath
- ☐ Insomnia
- ☐ Sleepy during the day

Have you or anyone else ever noticed that you snore? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

If yes, please describe _____

Has your medical doctor ever said you have a cancer or tumor? ◯ Yes ◯ No

How many days per week do you exercise? _____ What type? _____

How much water are you drinking each day? _____ Other drinks? _____

Have you had your spleen removed? ◯ Yes ◯ No Other Surgeries? _____

Do you have any disease, condition, or medical problem not listed? ◯ Yes ◯ No

If yes, please describe _____

For women: (Men, please skip to signature below)

Are you pregnant? ◯ Yes ◯ No If yes, what month? _____

Are you taking birth control pills? ◯ Yes ◯ No Do you have menopausal symptoms? ◯ Yes ◯ No

To the best of my knowledge, the above information is true and correct

Patient Signature _____ Date _____

Office Witness _____ Date _____

UPDATED:

Date _____ Patient _____ Office _____ // Date_____ Patient _____ Office_____ // Date_____ Patient_____ Office_____