Ages 18+

Adult Health History Form

Mondale DENTAL

Section 1 – About You

Patient Name: _____ Today's Date: _____/_____/_____
First MI Last

What Do You Prefer To Be Called? _____ ☐ Male ☐ Female Height: _____ Weight: _____

Birth-date: ____/____/____Age: ____ SS#: _____ How did you hear about us?_____

Mailing Address: _____unit/apt. #_____, _____
Street CITY STATE ZIP

Primary Phone #: (_____)_____ Work Phone #: (_____)_____ext.#____Cell Phone #: (_____)_____

E-mail address (for appointment confirmation): _____ Occupation: _____

*If you are completing this form for another person, what is your relationship to that person? _____

Do you have any of the following diseases or problems: Please circle one for each question (Y=Yes N=No ?=Unsure)

Active Tuberculosis	Y	N	?	Persistent cough greater than a 3-week duration	Y	N	?
Cough that produces blood	Y	N	?	Been exposed to anyone with tuberculosis	Y	N	?
Fever	Y	N	?	Lice	Y	N	?
Active cold sores	Y	N	?	Other contagious condition	Y	N	?

If you answered yes to any of the 8 items above, please stop and return this form to the receptionist.

Section 2 – Dental Info

*Reason for today's visit: ____Exam ____Emergency ____Consultation *Are you in pain? ☐ Yes ☐ No *If yes, how long? _____

Do you have or have you ever had any of the following: Please circle one for each question (Y=Yes N=No ?=Unsure)

Red, swollen or bleeding gums	Y	N	?	Teeth sensitivity to hot, cold, sweets, or pressure	Y	N	?	Lost/broken fillings	Y	N	?
Dry mouth	Y	N	?	Periodontal (gum) treatments (deep cleanings)	Y	N	?	Broken/chipped teeth	Y	N	?
Earaches or neck pain	Y	N	?	Orthodontic treatment (braces, retainers)	Y	N	?	Stained teeth	Y	N	?
Jaw clicking, locking, or discomfort	Y	N	?	Problems with previous dental treatment	Y	N	?	Bad breath	Y	N	?
Teeth clenching/grinding	Y	N	?	Fluoridated home water supply	Y	N	?	Loose teeth	Y	N	?
Sores or ulcers in or around mouth	Y	N	?	Drink bottled or filtered water	Y	N	?	Missing teeth	Y	N	?
Full or partial dentures	Y	N	?	Sports or active recreational activities	Y	N	?	Dental implants	Y	N	?
Ringing in ears	Y	N	?	Serious injury to head or mouth	Y	N	?	Mouth guard	Y	N	?

☐Others/Comments: _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐Yes ☐ No ☐ Don't know

Previous Dentist: _____ (____)_____ **Last dental exam:** ___/___/___ **Last dental X-rays:** ___/___/___
NAME PHONE #

*What type of toothbrush do you use? ☐ Soft ☐ Medium ☐ Hard ☐ Electric *Times per day you brush? _____ *Times per week you floss? _____

*How would you rate your smile? (1 *Worst*) 1 2 3 4 5 6 7 8 9 10 (10 *Best*)

*Would you like to change anything about your smile? _____*Are you interested in whitening? ☐ Yes ☐ No

Section 3 – Medical History

Are you taking any of the following types of medications:

Anti-anxiety	Y	N	?	Pain killers (including aspirin)	Y	N	?	Chemotherapy	Y	N	?
Muscle Relaxers	Y	N	?	Tranquilizers	Y	N	?	Anti-depressants	Y	N	?
Stimulants	Y	N	?	Insulin	Y	N	?	Recreational drugs	Y	N	?
Anti-coagulants (blood thinners)	Y	N	?	Osteoporosis medications	Y	N	?	Over-the-counter	Y	N	?

Other(s): _____

*Please list all medications, including vitamins, natural or herbal preparations and/or dietary supplements: _____

_____

*Please list any other medical condition, serious illness, operation, or hospitalization you have or have had: _____

_____

*Are you now under the care of a physician? ☐ Yes ☐ No *Date of last physical exam: _____/_____/_____ *Are you in good health? ☐ Yes ☐ No

*Physician: _____(___)_____, _____
Name Phone # Address

***Has there been any change in your general health within the past year?** ☐ Yes ☐ No (If yes, please explain): _____

_____

*Do you use tobacco? ☐ Yes ☐ No If yes: how used?_____ How long_____ Interested in stopping? ☐ Yes ☐No ☐ Don't Know

*Do you wear contact lenses? ☐ Yes ☐ No *Do you drink alcoholic beverages? ☐ Yes ☐No *If yes, how much alcohol did you drink in the last 24 hours? _____If yes, how much do you typically drink in a week? _____

*Please rate your general health: (1 *Worst*) 1 2 3 4 5 6 7 8 9 10 (10 *Best*)

Allergies: Are you allergic to or had a reaction to: (To all yes responses, specify type of reaction)

Local anesthetics	Y	N	?	Barbiturates, sedatives, or sleeping pills	Y	N	?	Latex (rubber)	Y	N	?
Penicillin/Amoxicillin	Y	N	?	Iodine	Y	N	?	Other antibiotics	Y	N	?
Tetracycline	Y	N	?	Codeine or other narcotics	Y	N	?	Food	Y	N	?
Sulfa drugs	Y	N	?	Hay fever/seasonal	Y	N	?	Metals	Y	N	?
Clindamycin	Y	N	?	Aspirin	Y	N	?	Animals	Y	N	?

☐ Other allergies: _____

***Joint replacement**: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No *Date: _____/_____/_____

*If yes, have you had any complications? ☐ Yes ☐ No

*Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ Yes ☐ No ☐ Don't Know

*Since 2001, were you treated or are you scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐No ☐ Don't Know

*If yes, date treatment began or scheduled to begin: _____/_____/_____

Do you have or have you had any of the following diseases, medical conditions or procedures?
Please circle one for each question ***(****Y=Yes N=No ?=Unsure)*

Cardiovascular disease	Y	N	?	Artificial (prosthetic) heart valve	Y	N	?	Emphysema	Y	N	?
Angina (chest pains)	Y	N	?	Previous infective endocarditis	Y	N	?	Sinus trouble	Y	N	?
Arteriosclerosis	Y	N	?	Damaged valves in transplanted heart	Y	N	?	Tuberculosis	Y	N	?
Congestive heart failure	Y	N	?	Diabetes: if yes, Type I -or- Type II (circle one)	Y	N	?	Ulcers	Y	N	?
Damaged heart valves	Y	N	?	G.E. Reflux/persistent heartburn	Y	N	?	Stroke	Y	N	?
Heart attack	Y	N	?	Gastrointestinal disease	Y	N	?	Eating disorder	Y	N	?
Heart murmur	Y	N	?	Thyroid problems	Y	N	?	Chronic pain	Y	N	?
Low blood pressure	Y	N	?	Systemic lupus erythematous	Y	N	?	Malnutrition	Y	N	?
High blood pressure	Y	N	?	Persistent swollen glands in neck	Y	N	?	HPV	Y	N	?
Other congenital heart defects	Y	N	?	Severe headaches/migraines	Y	N	?	Skin conditions	Y	N	?
Mitral valve prolapse	Y	N	?	Severe or rapid weight loss	Y	N	?	Difficulty breathing	Y	N	?
Pacemaker	Y	N	?	Sexually transmitted diseases	Y	N	?	Shingles	Y	N	?
Rheumatic fever	Y	N	?	Cancer/Chemotherapy/Radiation treatment	Y	N	?	Nervousness	Y	N	?
Abnormal bleeding	Y	N	?	Hepatitis, jaundice, or liver disease	Y	N	?	Scarlet fever	Y	N	?
Anemia	Y	N	?	Fainting spells	Y	N	?	Jaw Problems/TMD	Y	N	?
Blood transfusion: Date___/___/___	Y	N	?	Recurrent infection: Type_____	Y	N	?	Glaucoma	Y	N	?
Hemophilia	Y	N	?	Neurological disorders: Type_____	Y	N	?	Epilepsy/seizures	Y	N	?
AIDS or HIV infection	Y	N	?	Mental health disorders: Type_____	Y	N	?	Excessive urination	Y	N	?
Arthritis	Y	N	?	Chest pain upon exertion	Y	N	?	Kidney problems	Y	N	?
Autoimmune disease	Y	N	?	Congenital heart disease (CHD): (see below)	Y	N	?	Osteoporosis	Y	N	?
Rheumatoid arthritis	Y	N	?	• Unrepaired, cyanotic CHD	Y	N	?	Night sweats	Y	N	?
Asthma	Y	N	?	• Repaired (completely) in last 6 months	Y	N	?	Sleep disorder	Y	N	?
Bronchitis	Y	N	?	• Repaired CHD with residual defects	Y	N	?	Do you snore	Y	N	?

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ Yes ☐No

*If yes, please explain: _____

For women: *Are you taking Birth Control pills or hormonal replacement: ☐ Yes ☐ No *How many children have you had? _____

*Are you pregnant? ☐ Yes ☐ No ☐ Don't Know *If yes, how many weeks? _____ *Are you nursing? ☐ Yes ☐ No

Section 6 – In Event of Emergency

Whom should we contact? _____ Relation: _____

Home Phone #: (_____)_____Work Phone #: (_____)_____Cell Phone #: (_____)_____

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ ***Date*** ____/____/____

Signature of Dentist: _____ ***Date*** ____/____/____