WELLNESS SPRINGS DENTAL

ADULT HEALTH HISTORY

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Name: ______________________________ Date of Birth: ______________

Height: ______________ Weight: _____________ Date of last medical exam: _____________________

List any medications you are taking currently, including vitamins, herbs, OTC, birth control pills: ______________

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Are you allergic to, or have you reacted adversely to, any of the following:

Aspirin:	❒ Yes	❒ No	Codeine:	❒ Yes	❒ No			
Penicillin:	❒ Yes	❒ No	Erythromycin:	❒ Yes	❒ No	Latex:	❒ Yes	❒ No
Local Anesthetic:	❒ Yes	❒ No	Nitrous Oxide:	❒ Yes	❒ No			

Other (please describe): ____

Are you allergic to any foods? ❒ Yes ❒ No

If yes, please list: ____

Are you in good health? ❒ Yes ❒ No

Has there been any change in your health in the past year? ❒ Yes ❒ No

Are you under the care of a Physician? ❒ Yes ❒ No

If yes, for what condition(s)? ______________________________________

Physician's name: ______________________________ Specialty: _________________

Have you had any serious illness, operation or been hospitalized in the past 5 years? ❒ Yes ❒ No

If yes, for what condition(s)? ______________________________________

Do you smoke? ❒ Yes ❒ No

If yes, # of Packs per day: ________________ For how many years: ________________

Do you have a history of alcohol abuse and/or drug use? ❒ Yes ❒ No

If yes, please explain: ______________________________________

Are you using any recreational drugs?

If yes, please list______________________________________

Has your physician ever told you to take antibiotics prior to dental visits? ❒ Yes ❒ No

Have you ever had complications following dental treatment? ❒ Yes ❒ No

PLEASE CONTINUE ON PAGE TWO

Name: ______________________________ Date of Birth: ____________

Do you have, or have you had, any of the following disease or problems? Please check all that apply.

Condition	Yes	No	Condition	Yes	No
Anemia	❒ Yes	❒ No	HIV/AIDS	❒ Yes	❒ No
Angina	❒ Yes	❒ No	Jaundice	❒ Yes	❒ No
Arthritis	❒ Yes	❒ No	Kidney trouble	❒ Yes	❒ No
Artificial heart valve(s)	❒ Yes	❒ No	Liver disease	❒ Yes	❒ No
Artificial joints or grafts	❒ Yes	❒ No	Low blood pressure	❒ Yes	❒ No
Asthma	❒ Yes	❒ No	Pacemaker	❒ Yes	❒ No
Bleeding disorders	❒ Yes	❒ No	Painful joints	❒ Yes	❒ No
Bronchitis	❒ Yes	❒ No	Persistent diarrhea	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	Pneumonia	❒ Yes	❒ No
Chronic cough	❒ Yes	❒ No	Psychiatric problems	❒ Yes	❒ No
Chronic heartburn	❒ Yes	❒ No	Radiation therapy	❒ Yes	❒ No
Compromised immune system	❒ Yes	❒ No	Recent weight loss	❒ Yes	❒ No
Congenital heart defect	❒ Yes	❒ No	Respiratory problems	❒ Yes	❒ No
Coronary disease	❒ Yes	❒ No	Rheumatic heart disease	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No	Rheumatism	❒ Yes	❒ No
Emphysema	❒ Yes	❒ No	Sexually transmitted disease	❒ Yes	❒ No
Epilepsy/seizures	❒ Yes	❒ No	Severe “gag” reflex	❒ Yes	❒ No
Fainting spells	❒ Yes	❒ No	Sinus problems	❒ Yes	❒ No
Frequent urination	❒ Yes	❒ No	Sleep apnea	❒ Yes	❒ No
Gastric reflux	❒ Yes	❒ No	Stroke	❒ Yes	❒ No
Glaucoma	❒ Yes	❒ No	Swollen glands	❒ Yes	❒ No
Hay fever/allergies	❒ Yes	❒ No	Thyroid problems	❒ Yes	❒ No
Heart attack	❒ Yes	❒ No	TMJ disorder	❒ Yes	❒ No
Heart murmur	❒ Yes	❒ No	Tuberculosis	❒ Yes	❒ No
Hepatitis	❒ Yes	❒ No	Ulcers	❒ Yes	❒ No
High blood pressure	❒ Yes	❒ No			

Are you taking Bisphosphonates (e.g., Fosamax, Boniva) currently? ❒ Yes ❒ No

Have you ever taken Bisphosphonates? ❒ Yes ❒ No

If yes, when did you stop taking them: ______________________________

Women: Are you currently pregnant? ❒ Yes ❒ No

If yes, what is your due date: ______________________________

Are you nursing? ❒ Yes ❒ No

Is there any possibility that you might be pregnant? ❒ Yes ❒ No

I understand that withholding any information about my health could seriously jeopardize my safety. I have reviewed this health history form carefully and have answered all questions truthfully to the best of my knowledge. I will inform the doctors of any changes in my health.

______________________________ ______________
Signature of Patient or Legally Authorized Representative Date

______________________________ ______________
Printed Name of Patient or Representative Relationship to Patient