Parkview Family Dentistry Of Halfmoon,

Adult Health History Form

Patient Name: Birth Date: Date Created: Date 5/16/2016

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications,(prescriptions or over the counter), pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux? (For weight reduction)	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?(for diabetes, heart conditions or any other condition)	◯ Yes ◯ No	
Do you use tobacco? (smoking or chewing)	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness or condition not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Parkview Family Dentistry of Halfmoon, PLLC

DENTAL HISTORY

PATIENT NAME:_____ **Birth Date:**_____

Please circle YES or NO for each History Question:

Are your teeth Sensitive To:

Hot or Cold:	Present	Past	Never
Biting/Chewing:	Present	Past	Never
Sweets:	Present	Past	Never

Have You Ever Had:

Orthodontic Treatment:	Present	Past	Never
A bite plate or guard:	Present	Past	Never
Periodontic Treatment:	Present	Past	Never
Oral surgery:	Present	Past	Never
Serious Head or Neck injury:	Present	Past	Never

Comments/Explanation:

Please Indicate An Answer For Each Behavior/Habit Question:

Grind Teeth:	None	Potential	Manifested	Historical
Bite Cheek:	None	Potential	Manifested	Historical
Tongue Thrust:	None	Potential	Manifested	Historical
Mouth Breather:	None	Potential	Manifested	Historical
Bulimia/Anorexia:	None	Potential	Manifested	Historical
Cigar/Cigarette:	None	Potential	Manifested	Historical
Pipe:	None	Potential	Manifested	Historical
Bite Nails:	None	Potential	Manifested	Historical
Smokeless Tobacco:	None	Potential	Manifested	Historical
Thumb/Finger:	None	Potential	Manifested	Historical
Toothpick:	None	Potential	Manifested	Historical
Chewing Gum:	None	Potential	Manifested	Historical
Candy:	None	Potential	Manifested	Historical
Soft Drinks:	None	Potential	Manifested	Historical
Other:	None	Potential	Manifested	Historical

Description:_____

Comments/Explanations:

Please Indicate An Answer For Each General Question:

How often do you brush?_____
How often do you floss?_____
Other: _____
Emotional Motivators:_____
Emotional Concerns:_____

Toothpaste used:_____
Mouthwash used:_____
Oral Cancer: Yes No high risk
TMJ: Yes No
Gums Bleed: Brushing Flossing Neither Both

Pain in Upper Front Teeth:

Dental:	Low/High	Acute/Chronic	None
Mucosal/gums:	Low/High	Acute/Chronic	None

Pain in Lower Front Teeth:

Dental:	Low/High	Acute/Chronic	None
Mucosal/gums:	Low/High	Acute/Chronic	None

Pain in Upper Back Teeth:

Dental:	Low/High	Acute/Chronic	None
Mucosal/gums:	Low/High	Acute/Chronic	None

Pain in Lower Back Teeth:

Dental:	Low/High	Acute/Chronic	None
Mucosal/Gums:	Low/High	Acute/Chronic	None