PRESTON DENTAL CENTER

Dr. Gregory Mayes
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ADULT HEALTH HISTORY FORM

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *First* _____ *Middle* _____ *Last* _____ **Home Phone:** _____ **Cell Phone:** _____

Address: *Street* _____ *City* _____ *State* _____ *Zip* _____ **Email:** _____

Date of Birth: *MM* ____ / *DD* ____ / *YYYY* ____ **Social Security Number or Patient ID:** _____ **Height:** ____ **Weight:** ____ **Sex:** M F

Occupation: _____ **Company:** _____

Emergency Contact: _____ **Relationship:** _____ **Home Phone:** _____ **Cell Phone:** _____

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

Your Name: _____ **Relationship:** _____ **Cell Phone:** _____

Do you have any of the following disease or problems:	**Y**	**N**	**?**		**Y**	**N**	**?**
Active Tuberculosis				Persistent cough greater than a 3 week duration			
Cough that produces blood				Been exposed to anyone with tuberculosis			

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

DENTAL INFORMATION

Please mark (x) your response to indicate if you have or have not had any of the following disease or problems.

	Y	**N**	**?**		**Y**	**N**	**?**
Do your gums bleed when you brush or floss?				Are you currently experiencing dental pain or discomfort?			
Are your teeth sensitive to cold, hot, sweets, or pressure?				Do you have earaches or neck pains?			
Does food or floss catch between your teeth?				Do you have any clicking, popping or discomfort in the jaw?			
Is your mouth dry?				Do you brux or grind your teeth ?			
Have you had any periodontal (gum) treatments?				Do you have sores or ulcers in your mouth?			
Have you ever had orthodontic (braces) treatment?				Do you wear dentures or partials?			
Have you had any problems associated with previous dental treatment?				Do you participate in active recreational activities?			
Is your home water supply fluoridated?				Have you ever had a serious injury to your head or mouth?			
Do you drink bottled or filtered water?							

If yes, how often? Check one: Daily Weekly Occasionally

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Date of your last dental x-ray? *MM* ____ / *DD* ____ / *YYYY* ____

Date of your last dental exam? *MM* ____ / *DD* ____ / *YYYY* ____

What was done at that time? _____

MEDICATIONS

Please list any and all medications.

_____

_____

MEDICAL INFORMATION

Please mark (x) your response to indicate if you have or have not had any of the following disease or problems.

	Y	N	?
Do you wear contact lenses?			
Do you use controlled substances (drugs)?			
Do you use tobacco (smoking, snuff, chew)?			
Do you drink alcoholic beverages?			

Women Only	Y	N	?
Are you pregnant?			
If yes, how many weeks are you?			
Are you taking birth control pills or hormonal replacement?			
Are you nursing?			

Joint Replacement:

	Y	N	?
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement			

Date: _____ If yes, have you had any complications? _____

	Y	N	?
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?			
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			

Date Treatment Began: _____

Diseases & Medical Problems: *Please mark (x) your response to indicate if you have or have not had any of the following disease or problems.*

	Y	N	?
Artificial (prosthetic) heart valve			
Previous infective endocarditis			
Damaged valves in transplanted heart			
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD			
Repaired (completely) in last 6 months			
Repaired CHD with residual defects			
Cardiovascular disease			
Angina			
Arteriosclerosis			
Congestive heart failure			
Damaged heart valves			
Heart attack			
Heart murmur			
Low blood pressure			
High blood pressure			
Other congenital heart defects			
Mitral valve prolapse			
Pacemaker			
Rheumatic fever			
Rheumatic heart disease			
Abnormal bleeding			

	Y	N	?
Anemia			
Blood transfusion			
If yes, date: _____			
Hemophilia			
AIDS or HIV infection			
Arthritis			
Autoimmune disease			
Rheumatoid arthritis			
Systemic lupus erythematosus			
Asthma			
Bronchitis			
Emphysema			
Sinus trouble			
Tuberculosis			
Cancer/Chemotherapy/Radiation Treatment			
Chest pain upon exertion			
Chronic pain			
Diabetes Type I or II			
Eating disorder			
Malnutrition			
Gastrointestinal disease			
G.E. Reflux/persistent heartburn			

	Y	N	?
Ulcers			
Thyroid problems			
Stroke			
Glaucoma			
Hepatitis, jaundice or liver disease			
Epilepsy			
Fainting spells or seizures			
Neurological disorders			
If yes, specify: _____			
Sleep disorder			
Mental health disorders			
If yes, specify: _____			
Recurrent Infections			
If yes, type of infection: _____			
Kidney problems			
Night sweats			
Osteoporosis			
Persistent swollen glands in neck			
Severe headaches/migraines			
Severe or rapid weight loss			
Sexually transmitted disease			
Excessive urination			

Allergies: *Please mark (x) your response to indicate if you are allergic to any of the following. For all yes responses, please specify type of reaction.*

	Y	N	?
Local anesthetics			
Aspirin			
Penicillin or other antibiotics			
Barbiturates, sedatives, or sleeping pills			
Sulfa drugs			
Codeine or other narcotics			
Metals			

	Y	N	?
Latex (rubber)			
Iodine			
Hay fever/seasonal			
Animals			
Food			
Other: _____			

	Y	N	?
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			

Name of physician or dentist making recommendation: _____ Phone: _____

	Y	N	?
Do you have any disease, condition, or problem not listed above that you think we should know about?			

Please explain: _____

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:** _____