Health History - Adult
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We want you to know how very important it is that you provide a full disclosure of your total health profile, including history of past and present illness, allergies, medications (prescription, over the counter and herbal or homeopathic) and drug, alcohol and tobacco product use.

There is a direct and powerful relationship between the extent of information you provide and our ability to provide full and responsible support of your continued health.

As always, your privacy is assured and your information is protected.

Yours in wellness,
Dr. Drewyer and Staff

Date: ____/____/_____

Name: _____
FIRST MI LAST

Birthdate: _____/_____/_____

Date of last health care exam: _____

What was this exam for? _____

Have you been hospitalized in the last 5 years? Yes No

If yes, please explain briefly:

Are you currently receiving medical care? Yes No

If yes, what is the nature of care?

_____

_____

Please list all the names of physicians and/or healers who are currently providing your care and list the care they provide:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list date of Last Dental Appointment and reason for visit:

_____

For the following questions, please circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

Rheumatic Fever Yes No
Heart Murmur Yes No Type: _____
Mitral Valve Prolapse Yes No
Are you required to PRE-MEDICATE before dental treatment? Yes No
PACEMAKER Yes No
Abnormal Heart Condition Yes No Specify: _____
Heart (surgery, disease, attack) Yes No Specify: _____
Stroke Yes No
Abnormal Blood Pressure Yes No Specify: _____
Anemia Yes No
Abnormal Bleeding from a cut Yes No
Diabetes Yes No Type: _____
Hyper/Hypoglycemia Yes No
Epilepsy Yes No
Asthma Yes No
Emphysema/respiratory illness Yes No
Tuberculosis Yes No
Hepatitis Yes No Type: _____
Liver Disease (including Jaundice) Yes No
HIV positive Yes No
AIDS or AIDS related complex Yes No
Venereal Disease or any STDs Yes No
Unintentional Weight Loss/Gain Yes No
Blood Transfusion Yes No Year of transfusion: _____
Kidney Disease Yes No
Psychosis Yes No
Cancer Yes No Type: _____
Previous Biopsies Yes No
Reason for biopsy: _____
Radiation Treatment Yes No
If yes, reason for treatment: _____
Chemotherapy Treatment Yes No
If yes, reason for treatment: _____
Sore/Enlarged Lymph Nodes Yes No
Slow Healing Mouth Sores Yes No
Glaucoma Yes No
Headaches Yes No Type: _____
Thyroid Problems Yes No
Arthritis Yes No Type: _____
JOINT REPLACEMENT Yes No If yes, what joint(s): _____
Date of joint replacement surgery? _____

LATEX SENSITIVITY **Yes** **No**

Recurrent Illnesses Yes No

If yes, please explain: _____

_____

If there are **any** other medical conditions, infections, and health problems that are not listed above, please explain: _____

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

Local anesthetics	Yes	No	
Antibiotics	Yes	No	**SPECIFY:** _____
Aspirin	Yes	No	
Codeine, Valium or other sedatives	Yes	No	**SPECIFY:** _____

Please list any other allergies or drug sensitivities:

_____

_____

_____

Are you allergic or have you had a reaction to Iodine? Yes No

Do you have a chemical dependency? (Ex. Recreational drugs, alcohol, etc.)

_____

Are you a smoker? (Indicate cigarettes, cigars, pipes) _____If so, how much do you smoke per day? _____

Do you use any other tobacco products? (Ex. smokeless tobacco, chewing tobacco). Please indicate type: _____

Women Only: Are you pregnant?	Yes	No
If no, are you planning pregnancy?	Yes	No
Are you a nursing mother?	Yes	No
Using any pharmaceutical birth control?	Yes	No

If yes, what type? _____

Everyone:

Have you ever been diagnosed with Obstructive Sleep Apnea? Yes No

If YES: How is it managed? _____

Do you wake up with a dry mouth? Yes No

Do you wake up with a headache? Yes No

Do you clench or grind your teeth? Yes No

Are you aware or have you been told that you have a tendency for snoring? Yes No

Do you wake in the morning feeling refreshed? Yes No

Have you ever been told that you stop breathing during sleep? Yes No

More questions on the back>>>>>>>>>>>>>

Please list **any** medication you are currently taking and what *you* are taking it for:

_____

_____

_____

_____

_____

_____

Have you ever been treated with any long-term antibiotic medicines? Yes No

If yes, please provide name of antibiotic: _____

Do you take Antacids? Yes No How often: _____

Do you or have you experienced excess stomach acid? Yes No

Are you taking any vitamins, herbal supplements/medications? Yes No

If yes, please list: _____

Are you on a restricted diet? Yes No

If yes, please describe: _____

How many meals do you eat a day? _____

Do you have any food Allergies? Please list _____

Amount of sugar in your diet: None Slight Moderate High

Amount of sodium in your diet: None Slight Moderate High

Are there any prior dental office experiences you would like to share with us? Yes No

Is there anything you would like us to know about your dental health?

_____

Do you have any questions about your teeth?

_____

Please add any information you feel is important for us to know:

_____

Signature: _____

For Doctor's use only:

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management consideration: _____