ADULT HEALTH HISTORY

(Patients 18 years of age and older)

Snyder Dentistry

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PATIENT NAME:_____ **BIRTH DATE:**_____

MEDICAL HISTORY

Physician_____ Date of last exam/physical_____

Have you been hospitalized or had a serious illness/injury within the last year? Yes No
If yes, please explain_____

Women Only: Are you currently: Pregnant/trying to get pregnant? Yes No Nursing? Yes No

Do you have, or have you had, any of the following? ***Please circle (Y) Yes or (N) No***

Abnormal Bleeding	Y	N	Congenital Heart Disorder	Y	N	Pacemaker	Y	N
Alzheimer's Disease	Y	N	Diabetes	Y	N	Psychiatric Care	Y	N
Anemia	Y	N	Epilepsy or Seizures	Y	N	Radiation Treatments	Y	N
Angina	Y	N	Fainting/Dizziness	Y	N	Stroke	Y	N
Artificial Heart Valve	Y	N	Heart Attack/Failure	Y	N	Thyroid Disease	Y	N
Artificial Joint	Y	N	Heart Disease	Y	N	Tumors or Growths	Y	N
Asthma	Y	N	Heart Murmur	Y	N			
High Blood Pressure	Y	N	Hepatitis	Y	N	Other :_____		
Cancer	Y	N	HIV+/AIDS	Y	N			
Chest Pains	Y	N	Irregular Heartbeat	Y	N	_____		
Cold Sores/Fever Blisters	Y	N	Kidney Problems	Y	N			

If you answered *yes* to any of the above, please explain:_____

_____

Please list any medications you are currently taking (including over-the-counter, vitamins, natural remedies):

_____

Do you have any known allergies? Yes No

If yes, are you allergic to any of the following? *(please circle)* Penicillin Codeine Erythromycin Local Anesthetics

Metals Dyes Acrylic Sulfa Latex Epinephrine Other_____

If you answered *yes* to any of the above, please explain the reaction that occurs_____

Do you use recreational drugs? Yes No Do you smoke? Yes No

Do you use chewing tobacco? Yes No Are you interested in quitting? Yes No

DENTAL HISTORY

Name of Previous Dentist and Location_____ Date of last visit_____

Please list any complications associated with previous dental treatment:_____

Have you been told by a physician or previous dentist that you require antibiotics prior to dental treatment? Yes No

Have you been told you have periodontal (gum) disease? Yes No Do you clench or grind your teeth? Yes No

I certify that I have read and understood the information on this form. The questions have been accurately answered to the best of my knowledge. I understand that providing incorrect or incomplete information can be dangerous to my health.
It is my responsibility to inform the dentist and staff of any changes to my health or medical status.

_____ _____

PATIENT SIGNATURE **DATE**