WATERFORD FAMILY DENTAL  **ADULT HEALTH HISTORY**

Date: _____

Patient Name:_____ I prefer to be called_____

Sex: ☐ Male ☐ Female Birthdate: _____ Age: _____ SS#: _____

Home Address: _____

_____

City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home#: _____ Cell#: _____

Work#: _____ Employer: _____

Email: _____

How would you like to be confirmed for your appointment? ☐ Phone ☐ E-mail ☐ Text Message

If text message who is your cell phone provider:

☐ US Cellular ☐ Verizon ☐ Sprint ☐ AT&T ☐ T-Mobile ☐ Other_____

Where & when are the best times to reach you? _____

Who may we thank for referring you? _____

Other family members seen by us: _____

Spouse Information

His/Her name: _____ Birthdate: _____

Cell#: (____)_____ SS#: _____

Dental History

Previous / Present Dentist: _____ Date last seen: _____

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor Do you like your smile? ☐ Yes ☐ No

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Do you have a history of cold sores or fever blisters? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Fresher Breath? ☐ Yes ☐ No

How many times a week do you floss? _____ How many times a day do you brush? _____

Allergies

Are you allergic to any of the following? (please circle)

Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin
Dental Anesthetics	Latex	Tetracycline

Please list any other drugs/materials that you are allergic to: _____

_____

Do you have a history of pain/tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Have you ever had difficult extractions? ☐ Yes ☐ No

Have you ever had prolonged bleeding following extractions? ☐ Yes ☐ No

Are there currently any growths or sores in or around your mouth? ☐ Yes ☐ No

Do you habitually clench or grind your teeth during the day or night? ☐ Yes ☐ No

Have you ever been told you have gum problems? ☐ Yes ☐ No

Have you ever been seen by a gum specialist/Periodontist? ☐ Yes ☐ No

For Women

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? : ☐ Yes ☐ No Week #: _____ Are you nursing? : ☐ Yes ☐ No

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you have a personal physician? ☐ Yes ☐ No Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No If Yes, please explain:

_____

_____

WATERFORD FAMILY DENTAL **ADULT HEALTH HISTORY**

Are you taking any **prescription medications** or **over-the-counter** or **herbal drugs**? ☐ Yes ☐ No

Please list each one:

_____

_____

Have you ever taken Fosamax (Boniva), or any other bisphosphonate: ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	☐ Yes ☐ No	Alcohol / Drug abuse	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Artificial Bones/Joints/Valves	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Cancer/Chemotherapy	☐ Yes ☐ No
Colitis	☐ Yes ☐ No	**Congenital Heart Defect**	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Difficulty Breathing	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Fainting Spells	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	**Heart Murmur**	☐ Yes ☐ No
Heart Surgery	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Herpes / Fever Blisters	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	HIV+ / AIDS	☐ Yes ☐ No
Hospitalized for any reason	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	**Pacemaker**	☐ Yes ☐ No
Psychiatric Problems	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Rheumatic/Scarlet Fever	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Sickle Cell Disease/Traits	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No

Please list any serious medical condition(s) that you have ever had:

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Signature Date