

ADULT HEALTH HISTORY

PERSONAL

First Name: _____ Last Name: _____ MI: _____ M / F

Preferred Name/Nickname (if any) _____ Birth Date: _____

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.

MEDICAL HISTORY *Please circle (Y) Yes or (N) No*

- Are you under a physician's care now? Y N If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Y N If yes, please explain: _____
- Have you had a serious head or neck injury? Y N If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Y N If yes, please explain: _____
- Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Y N If yes, please explain: _____
- Are you on a special diet? Y N If yes, please explain: _____
- Do you use tobacco? Y N If yes, please explain: _____
- Do you use controlled substances? Y N If yes, please explain: _____

Women Only: Are you currently:

Pregnant/trying to get pregnant? Y N Nursing? Y N Taking oral contraceptives? Y N

Allergies: Are you allergic to any of the following? (*Please circle any applicable answers*)

Aspirin Penicillin Codeine Acrylic Other: _____
 Metal Latex Sulfa Drugs Local Anesthetics _____

Please explain your reaction: _____

Do you have or have you had, any of the following? *Please check the box next to the applicable answer.*

- AIDS/HIV Positive
- Alzheimer's Disease
- Anaphylaxis
- Anemia
- Angina
- Arthritis/Gout
- Artificial Heart Valve
- Artificial Joint
- Asthma
- Blood Disease
- Blood Transfusion
- Breathing Problems
- Bruise Easily
- Cancer
- Chemotherapy
- Chest Pains
- Cold Sores/Fever Blisters
- Congenital Heart Disorder
- Convulsions
- Cortisone Medicine
- Diabetes
- Drug Addiction
- Easily Winded
- Emphysema
- Epilepsy or Seizures
- Excessive Bleeding
- Excessive Thirst
- Fainting/Dizziness
- Frequent Cough
- Frequent Diarrhea
- Frequent Headaches
- Genital Herpes
- Glaucoma
- Hay Fever
- Heart Attack/Failure
- Heart Murmur
- Heart Pacemaker
- Heart Trouble/Disease
- Hemophilia
- Hepatitis A
- Hepatitis B or C
- Herpes
- High Blood Pressure
- High Cholesterol
- Hives or Rash
- Hypoglycemia
- Irregular Heartbeat
- Kidney Problems
- Leukemia
- Liver Disease
- Low Blood Pressure
- Lung Disease
- Mitral Valve Prolapse
- Osteoporosis
- Pain in Jaw Joints
- Parathyroid Disease
- Psychiatric Care
- Radiation Treatments
- Recent Weight Loss
- Renal Dialysis
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Shingles
- Sickle Cell Disease
- Sinus Trouble
- Spina Bifida
- Stomach/Intestinal Disease
- Stroke
- Swelling of Limbs
- Thyroid Disease
- Tonsillitis
- Tuberculosis
- Tumors or Growths
- Ulcers
- Venereal Disease
- Yellow Jaundice

Have you ever had any serious illness not listed above? _____
 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): (You may also attach a list.) _____

DENTAL HEALTH HISTORY

Reason for today's visit: _____

Former Dentist: _____ City/State: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Do you have or have you had, any of the following? Please check the box next to the applicable answer.

- | | | |
|---|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Sensitivity to heat | <input type="checkbox"/> Fingernail biting |
| <input type="checkbox"/> Burning sensation on tongue | <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Lip or cheek biting |
| <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Sensitivity when biting or chewing | <input type="checkbox"/> Chew on any foreign objects (e.g. toothpicks, ice) |
| <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Chew on one side of your mouth | <input type="checkbox"/> Mouth breathing |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Difficult or serious problem associated with previous dental work |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Pain/discomfort in your jaw joint | <input type="checkbox"/> Orthodontic treatment |
| <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Jaw tiredness | <input type="checkbox"/> Retainers |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Bitesplint or mouth guard |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Not happy with your smile |
| <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Chewing tobacco | |
| <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Grinding teeth | |

Home Dental Care

How often do you brush your teeth? _____ times per day _____ times per week

What type of toothbrush do you use? (Please circle one) Electric Manual: Hard Medium Soft Extra-Soft

How often do you floss your teeth? _____ times per day _____ times per week occasionally never

List any other tools or mouth rinses you use to clean your teeth: _____

Do you drink city water, well water, bottled water, or from another source? Please circle your main source of water.

Do you drink fluoridated water? YES NO DON'T KNOW If yes, how much fluoride is in the water? _____ ppm

Anything else you would like to add about the care of your teeth at home? _____

Diet

How many meals per day do you eat? _____

How many between meal snacks (including drinks other than water) do you have on an average day? _____

Do you chew gum with sugar in it? YES NO If yes, how often? _____ times per day _____ times per week

Do you eat dried fruit, sticky carbohydrates, hard candies, or lozenges? YES NO Please circle the ones that are applicable.

Would you like to make any comments about your diet? _____

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 Langhorst Family Dentistry, PLLC or Sarah Langhorst, DDS of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____