Langhorst Family Dentistry, PLLC • Sarah Langhorst DDS • 3235 N. Wellness Dr. Suite A-240 • Holland, MI 49424 • 616-377-7708

ADULT HEALTH HISTORY

PERSONAL

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

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

OVER→

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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.*

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

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: _____