ADULT HEALTH HISTORY

Patient SS# Age
Birthdate
Address Phone ______________
Patient's Occupation Phone
Business Address
Spouse's Name
Spouse's Occupation Phone
Business Address
Dentist Physician
Referred By
Dental Insurance

	yes	no
Do you have any health problems?	__	__
Has there been any change in your health the past year?	__	__
Are you under the care of a physician?	__	__
If so,what is the condition being treated ______________________________	__	__
Are you allergic to aspirin or penicillin?	__	__
Do you have any allergies ?	__	__
Are you taking any medications?	__	__
If so, what? ____		
Are you pregnant?	__	__
Do you have or have you had any of the following?		
-Rheumatic fever or rheumatic heart disease?	__	__
-Congenital heart lesions or murmurs?	__	__
-Cardiovascular disease?(high blood pressure,heart attack)	__	__
-Asthma or hay fever?	__	__
-Fainting spells or seizures?	__	__
-Diabetes?	__	__
-Hepatitis,jaundice or liver disease?	__	__
-Arthritis or inflammatory rheumatism?	__	__
-Kidney trouble?	__	__
-Tuberculosis?	__	__
-Blood disorders?	__	__
Do you have any disease, condition or problem not listed above that you think I should know about?	__	__

If so,please explain ____

______________________________ Signature Patient/Parent and Date

______________________________ Doctor Signature and Date

______________________________ Update by Doctor

______________________________ Update by Doctor