FAMILY HEALTHCARE OF HAGERSTOWN

Adult Health History
Ages 15 and older

Patient Name: _____ Today's Date: _____

Former dentist: _____ Date of last dental visit: _____

Reason for visit: _____

Dental History

Have you ever had any of the following:

Bad breath	☐ Yes	☐ No		Lip or cheek biting	☐ Yes	☐ No	
Bleeding gums	☐ Yes	☐ No		Loose teeth or broken fillings	☐ Yes	☐ No	
Blisters on lips or mouth	☐ Yes	☐ No		Mouth breathing	☐ Yes	☐ No	
Burning sensation on tongue	☐ Yes	☐ No		Mouth pain, brushing	☐ Yes	☐ No	
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No		Orthodontic treatment	☐ Yes	☐ No	
Clicking or popping jaw	☐ Yes	☐ No		Pain around ear	☐ Yes	☐ No	
Dry mouth	☐ Yes	☐ No		Periodontal (gum) treatment	☐ Yes	☐ No	
Food collection between the teeth	☐ Yes	☐ No		Sensitivity to cold/hot/sweets	☐ Yes	☐ No	
Grinding teeth	☐ Yes	☐ No		Sensitivity when biting	☐ Yes	☐ No	
Gums swollen or tender	☐ Yes	☐ No		Sores or growths in mouth	☐ Yes	☐ No	
Jaw pain or tiredness	☐ Yes	☐ No					

How often do you floss? Once a day Twice a day Several times a day Never Other

How often do you brush? Once a day Twice a day Several times a day Never Other

Health History

Physicians Name: _____ Date of last visit: _____

Have you ever had any of the following:

AIDS/HIV	☐ Yes	☐ No		Herpes	☐ Yes	☐ No	
Anemia	☐ Yes	☐ No		High blood pressure	☐ Yes	☐ No	
Arthritis/Rheumatism	☐ Yes	☐ No		Jaw pain	☐ Yes	☐ No	
Artificial heart valves	☐ Yes	☐ No		Kidney disease	☐ Yes	☐ No	
Artificial joints	☐ Yes	☐ No		Liver disease/jaundice	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No		Low blood pressure	☐ Yes	☐ No	
Back problems	☐ Yes	☐ No		Nervous problem	☐ Yes	☐ No	
Bleeding abnormally with surgery	☐ Yes	☐ No		Pacemaker	☐ Yes	☐ No	
Blood disease	☐ Yes	☐ No		Psychiatric care	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No		Radiation treatment	☐ Yes	☐ No	
Chemical dependency	☐ Yes	☐ No		Respiratory disease	☐ Yes	☐ No	
Chemotherapy	☐ Yes	☐ No		Shortness of breath	☐ Yes	☐ No	
Circulatory problems	☐ Yes	☐ No		Sinus trouble	☐ Yes	☐ No	
Congenital heart lesions	☐ Yes	☐ No		Skin rash	☐ Yes	☐ No	
Cortisone treatments	☐ Yes	☐ No		Special diet	☐ Yes	☐ No	
Cough, persistent or bloody	☐ Yes	☐ No		Stroke	☐ Yes	☐ No	
Diabetes (type)	☐ Yes	☐ No		Swollen feet or ankles	☐ Yes	☐ No	
Emphysema	☐ Yes	☐ No		Thyroid problems	☐ Yes	☐ No	
Do you wear contact lenses?	☐ Yes	☐ No		Tonsillitis	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No		Tuberculosis	☐ Yes	☐ No	
Fainting or dizziness	☐ Yes	☐ No		Tumor or growth on head or neck	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No		Ulcer	☐ Yes	☐ No	
Headaches	☐ Yes	☐ No		Venereal disease	☐ Yes	☐ No	
Heart problems	☐ Yes	☐ No		Weight loss	☐ Yes	☐ No	
Hepatitis (type)	☐ Yes	☐ No		Other _____			

Medications

Please list any medications you are currently taking and reason.

Medication	Reason

Have you ever taken any of the group drugs referred to as "Fen-Phen"? These include combinations of Lonimin, Adipex, Fastin (all brand names of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine)

☐ Yes ☐ No

Have you used a bisphosphonate medication? Common brands are Fosamax, Actonel, Atelvia, Didronel, Boniva

☐ Yes ☐ No

Allergies

Aspirin	☐	Yes	☐	No	Local Anesthetic	☐	Yes	☐	No
Sleeping pills	☐	Yes	☐	No	Penicillin	☐	Yes	☐	No
Codeine	☐	Yes	☐	No	Sulfa	☐	Yes	☐	No
Iodine	☐	Yes	☐	No	Other:_____	☐	Yes	☐	No
Latex	☐	Yes	☐	No					

Women

Are you pregnant?	☐	Yes	☐	No
Are you nursing?	☐	Yes	☐	No
Are you taking birth control pills?	☐	Yes	☐	No

If yes, due date: _____

_____
Signature of Patient

_____
Date

_____
Printed Name of Patient