

Dental

Adult & Child Health History

To meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history.

Name: (Last) _____ (First) _____ (MI) _____ Date of Birth: _____ Age: _____

1. PAST MEDICAL HISTORY: Have you ever had the following: _____ Patient denies any illnesses

Condition	Date	Condition	Date	Condition	Date
Anemia		Asthma		Epilepsy	
Diabetes		Rheumatic Fever		Hypertension	
Heart Disease		Kidney Disease		Hepatitis	
Bone Disease		HIV		Other	

2. PAST SURGICAL HISTORY : Have you ever had the following: _____ Patient denies any surgeries

Surgery	Date	Surgery	Date	Surgery	Date
Pacemaker		Joint Replacement		Oral Surgery	
Bone Fracture		Back Surgery		Other	

3. MEDICATIONS: Please list ALL medications you are currently taking. _____ Patient denies any medications

Name of Medication	Dosage (mg)	How Often

4. ALLERGIES: Please list ALL allergies (food, drugs, and environment) _____ Patient denies any allergies

Allergen	Reaction
Latex Gloves	
Other	

5. FAMILY HISTORY: Has any blood relative had the following: _____ Patient denies any family history

Condition	Relationship	Condition	Relationship	Condition	Relationship
Cancer		Heart Disease		Hypertension	
Diabetes		Anesthesia		Other	

6. SOCIAL HISTORY: _____ Patient denies any social history

Tobacco: _____ Never _____ Minimal _____ Yes (_____ packs/day for _____ years) _____ Quit _____ years ago
Alcohol: _____ Never _____ Minimal _____ Yes (_____ less than 10 drinks per week _____ more than 10 drinks per week)
Recreational Drugs: _____ Never _____ Minimal _____ Yes Type: _____

Printed name of person completing this form: _____ Relationship to patient: _____

Signature: _____ Date: _____