Heritage Family Dental
General, Cosmetic & Implant Dentistry
Dr. Larisa Sokolson
Dr. Robert Burstein

ADULT HEALTH HISTORY

Email: _____ Today's Date: ____/____/_____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____
Last First Middle

Home Phone: (____) _____
Please include area code.

Business/Cell Phone: (____) _____
Please include area code.

Address: _____
Mailing address

City: _____ State: _____ ZIP: _____

Occupation: _____ Height: _____ Weight: _____ Date of Birth: _____ Sex: M F

SS# or Patient ID: _____ Emergency Contact: _____
First and last name

Relationship: _____

Home Phone: (____) _____
Please include area code.

Business/Cell Phone: (____) _____
Please include area code.

If you are completing this form for another person, what is your relationship to that person?

_____ _____
Your first and last name *Relationship*

Do you have any of the following diseases or problems: ***(Check "DK" if you don't know the answer to the question.)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3-week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer "Yes" to any of the four items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) to indicate your response to each question.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you ever had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottle or filtered water?	☐	☐	☐
If yes, how often? CIRCLE ONE: DAILY | WEEKLY | OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

What is the reason for your dental visit today?

How do you feel about your smile?

Date of your last dental exam:

What was done at that time?

Date of last dental X-rays:

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you had a serious injury to your head or mouth?	☐	☐	☐
Has anyone ever complained about your loud snoring?	☐	☐	☐
Do you often feel tired or sleepy, or struggle to concentrate and stay awake in the afternoon?	☐	☐	☐
Has anyone ever observed that while sleeping, you choke, gasp, or stop breathing?	☐	☐	☐
Have you ever had high blood pressure, or are you being treated for it?	☐	☐	☐
Is your body mass index (BMI) more than 35 kg/m^2?	☐	☐	☐
Are you older than 50 years of age?	☐	☐	☐
Is your neck size greater than 16 inches?	☐	☐	☐
Is your sex Male?	☐	☐	☐

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

Please see the reverse side to complete this form.

For the following questions, please mark (X) to indicate your response to each question.

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐

Date Treatment began: _____

Are you allergic to or have you had a reaction to:

To all "Yes" responses, specify the type of reaction.

Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐

If so, how interested are you in stopping? VERY | SOMEWHAT | NOT INTERESTED

Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual effects	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

WOMEN ONLY:

Are you:	Yes	No	DK
Pregnant?	☐	☐	☐
If yes, number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes: Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Hepatitis, jaundice, or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: _____			
Recurrent infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended you that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: Phone:

Do you have any disease, condition or problem not listed above that you think I should know about? Please explain:

NOTE: Both Doctor and Patient are encouraged to discuss any and all relevant patient issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.

Signature of Patient / Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments:

Medical Information

For the following questions, please mark (X) to indicate your response to each question.

	Yes	No	DK
Are you currently under the care of a physician?.....	☐	☐	☐

Physician Name: Phone:

_____ _____

Please include area code.

Address/City/State/ZIP:

_____

_____

	Yes	No	DK
Have you had a serious illness, operation, or been hospitalized in the past five years? ……..	☐	☐	☐

If yes, what was the illness or problem?

Are you currently taking or have you recently taken any prescription or over-the-counter medicine(s)?.....	☐	☐	☐

If so, please list all medications below, including vitamins, natural or herbal preparations and/or diet supplements: