

Patient Name: _____

Updated Adult Health & Social History

To be updated every year

1) Does the patient have any health problems (past or present)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain _____		
2) Is the patient currently seeing a physician for any problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain _____		
3) Does the patient take any medications?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain _____		
4) Does the patient have any allergy to any food, medicine or materials (e.g. antibiotics, latex)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain _____		
5) Has the patient ever had a heart murmur, heart defect or rheumatic fever?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain _____		
6) Has the patient ever been injured, hospitalized or received surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain _____		
7) Ever taken oral bisphosphonates (i.e. Fosamax, Actonel)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8) Currently pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9) Currently nursing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10) Has the patient been pregnant in the past?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11) Has the patient ever had a blood transfusion?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Has the patient ever had any of the following?

Breathing problems or asthma?	Y / N	Airway, tonsil or adenoid problems?	Y / N
Blood problems such as sickle cell anemia?	Y / N	Easy bleeding on brushing?	Y / N
AIDS or HIV infection?	Y / N	Frequent headaches?	Y / N
Frequent cough or tuberculosis (T.B.)?	Y / N	Hepatitis or liver problems?	Y / N
Stomach, bowel problems or gastric reflux?	Y / N	Diabetes, excessive thirst or urination?	Y / N
Endocrine or hormone problems?	Y / N	Kidney problems?	Y / N
Hives or skin rash?	Y / N	Seizures, dizziness, fainting spells or epilepsy?	Y / N
General anesthesia?	Y / N	Birth defect or disability?	Y / N

1) Does the patient have or had any disease or condition not listed above?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain _____		
2) Does anyone in the immediate family have history of allergies, diabetes, etc.?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain _____		
3) Did the patient have any health problems or illnesses when younger or at birth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain _____		
4) Does the patient have any emotional, behavior or learning problems (e.g. ADD/ADHD)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, explain _____		
5) Has the patient related well to previous treatments?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If no, explain _____		

Name of Patient's Primary Care Physician: _____ Date of Last Physical: _____

To the best of my knowledge, the above information is complete and accurate. Providing incorrect information can be dangerous to my health and I will inform the dental office of any changes in my medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered during the period of such dental care to third party payers and/or other health practitioners.

Patient's Name: _____

Signature: _____ Date: _____

For Office Use Only:

Reviewed By:

Provider's Name: _____

Signature: _____ Date: _____