BELLGRADE DENTAL CENTER

ADULT HEALTH HISTORY

NAME ______________________________ DATE ____________________

DATE OF BIRTH ______________________________

PHARMACY

PHARMACY NAME ______________ PHONE # (   ) ____________

ALLERGIES

(INCLUDING LATEX)

OR **NONE**

____

MEDICATIONS

(LIST ALL MEDICATIONS OR PURPOSE)

OR **NONE**

____

Are you taking meds for OSTEOPOROSIS? _________

Including FOSAMAX / ACTONEL / BONIVA? _________

MEDICAL HISTORY (CHECK THOSE THAT APPLY)

HEART VALVE DISEASE (MURMUR)____

HEADACHES ___

CANCER ___

ULCER ___

DIABETES ___

BACK PROBLEMS ___

RESPIRATORY DISEASE ___

ARTIFICIAL HEART VALVE ___

RHEUMATIC FEVER ___

CURRENTLY PREGNANT ___

PSYCHIATRIC CARE ___

COLD SORES/ FEVER BLISTERS___

EPILEPSY ___

HEMOPHILIA ___

STROKE ___

CIRCULATORY PROBLEMS ___

NERVOUS PROBLEMS ____

CHEMO/RADIATION TX ____

ASTHMA ____

CHEMICAL DEPENDENCY ___

VENEREAL DISEASE ___

POSSIBLY PREGNANT ___

SNORING ___

WELL WATER/BOTTLED WATER___

TUBERCULOSIS ___

HEART ARTERY DISEASE___

HIGH/LOW BP _____

HIV/AIDS ___

SCARLET FEVER ___

ARTHRITIS ____

THYROID DISEASE ___

ARTIFICIAL JOINTS ___

CURRENTLY NURSING ___

HEPATITIS ___

MOUTH ULCERS/CANKER SORES___

HAVE YOU EVER HAD AN ADVERSE REACTION TO DENTAL TREATMENT OR ANESTHETICS? IF YES PLEASE EXPLAIN.

____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING OPERATIONS, OR OTHER MEDICAL OR DENTAL INFORMATION THAT MAY POSSIBLY AFFECT YOUR CARE.

____

PHYSICIAN NAME ____________________ PHYSICIAN PHONE # ____________________