MONTAGUE DENTAL

Adult Web Form

Patient Health History

Patient Name ______________________________ Date of Birth ____________________

Welcome to our office. Will you please fill out this short Health History form so we may be aware of any problems you may have or have had. Use the Additional Comments are at the end of the form to include any extra information. Thank you.

Please circle YES or NO or fill in where appropriate:

Primary reason for this appointment ______________________________

Name of your physician ______________________________

Physician's address ______________________________

Physician's phone number ______________________________

Date of last visit to physician ______________________________

Are you in good health? .... Yes No

Has there been any change in your health since last year? .... Yes No

Have you had any serious illness, operation or hospitalization within the the past 5 years? .... Yes No

Are you taking any medicine(s) including non-Prescription? .... Yes No

Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves, artificial valves or murmur .... Yes No

b. Rheumatic Heart Disease .... Yes No

c. Arteriosclerosis .... Yes No

d. High blood pressure .... Yes No

e. Heart trouble, heart attack, angina, or any other heart condition .... Yes No

1. Chest pain on exertion? .... Yes No
2. Shortness of breath after mild exercise? .... Yes No
3. Do your ankles swell? .... Yes No

f. Allergy i.e. foods, plants, latex, etc. .... Yes No

g. Sinus trouble .... Yes No

h. Asthma or hay fever .... Yes No

i. Fainting spells or seizures .... Yes No

j. Diabetes .... Yes No

k. Hepatitis, jaundice or liver disease .... Yes No

l. Frequent or recurring mouth sores .... Yes No

m. Thyroid problems .... Yes No

n. Respiratory problems .... Yes No

o. Arthritis or painful, swollen joints .... Yes No

p. Stomach ulcer or hyperacidity .... Yes No

q. Kidney trouble .... Yes No

r. Tuberculosis .... Yes No

s. Persistent cough or cough that produces blood .... Yes No

t. Persistent swollen neck glands .... Yes No

u. Epilepsy or neurological disorder .... Yes No

v. Mental Health Issues .... Yes No

w. Cancer .... Yes No

x. Problems of the immune system .... Yes No

Have you had abnormal bleeding? .... Yes No

a. Have you ever required a blood transfusion? .... Yes No

Do you have any blood disorder such as anemia? .... Yes No

Have you ever had treatment for a tumor or growth? .... Yes No

Are you allergic or have you had reaction to:

a. Local anesthetics .... Yes No

b. Penicillin or antibiotics .... Yes No

c. Sulfa drugs .... Yes No

d. Barbituates or sleeping pills .... Yes No

e. Asprin .... Yes No

f. Iodine .... Yes No

g. Codeine or other narcotics .... Yes No

h. Other .... Yes No

Do you now or have you ever used tobacco products? .... Yes No

Have you had any serious trouble associated with previous dental treatment? .... Yes No

If so, explain ____________________

Do you have any other condition or disease you think we should know about,

but would prefer to discuss privately rather than writing them down? .... Yes No

Are you wearing contact lenses? .... Yes No

Are you wearing removable dental appliances? .... Yes No

Women:

Are you pregnant? .... Yes No

Do you have problems associated with your menstrual period? .... Yes No

Are you nursing? .... Yes No

Are you taking birth control pills? .... Yes No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any error or omissions that I may have made in the completion of this form.

X ____________________ ____________________

Signature of patient or guardian Date

MEDICAL HISTORY UPDATE:

SIGNATURE	COMMENTS	DATE
____________________	____________________	____________________