Health History - Adult
Douglas G. Drewyer, D.D.S., M.A., L.L.C.

We want you to know how very important it is that you provide a full disclosure of your total health profile, including history of past and present illness, allergies, medications (prescription, over the counter and herbal or homeopathic) and drug, alcohol and tobacco product use.

There is a direct and powerful relationship between the extent of information you provide and our ability to provide full and responsible support of your continued health.

As always, your privacy is assured and your information is protected.

Yours in wellness,

Dr. Drewyer and Staff

Date: ____/____/____

Name: _____
FIRST MI LAST

Birthdate: _____/_____/_____

Date of last health care exam: _____

What was this exam for? _____

Have you been hospitalized in the last 5 years? Yes No

If yes, please explain briefly: _____

_____

_____

Are you currently receiving medical care? Yes No

If yes, what is the nature of care?

_____

_____

Please list all the names of physicians and/or healers who are currently providing your care and list the care they provide:

1._____

2._____

3._____

4._____

5._____

For the following questions, please circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

Rheumatic Fever	Yes	No	
Heart Murmur	Yes	No	**Type:** _____
Mitral Valve Prolapse	Yes	No	

Are you required to PRE-MEDICATE before dental treatment? Yes No

PACEMAKER	**Yes**	**No**	
Abnormal Heart Condition	Yes	No	**Specify:** _____
Heart (surgery, disease, attack)	Yes	No	**Specify:** _____
Stroke	Yes	No	
Abnormal Blood Pressure	Yes	No	**Specify:** _____
Anemia	Yes	No	
Abnormal Bleeding from a cut	Yes	No	
Diabetes	Yes	No	**Type:** _____
Hyper/Hypoglycemia	Yes	No	
Epilepsy	Yes	No	
Asthma	Yes	No	
Emphysema/respiratory illness	Yes	No	
Tuberculosis	Yes	No	
Hepatitis	Yes	No	**Type:** _____
Liver Disease (including Jaundice)	Yes	No	
HIV positive	Yes	No	
AIDS or AIDS related complex	Yes	No	
Venereal Disease or any STDs	Yes	No	
Unintentional Weight Loss/Gain	Yes	No	
Blood Transfusion	Yes	No	**Year of transfusion:** _____
Kidney Disease	Yes	No	
Psychosis	Yes	No	
Cancer	Yes	No	**Type:** _____
Previous Biopsies	Yes	No	

Reason for biopsy: _____

Radiation Treatment	Yes	No	

If yes, reason for treatment: _____

Chemotherapy Treatment	Yes	No	

If yes, reason for treatment: _____

Sore/Enlarged Lymph Nodes	Yes	No	
Slow Healing Mouth Sores	Yes	No	
Glaucoma	Yes	No	
Headaches	Yes	No	**Type:** _____
Thyroid Problems	Yes	No	
Arthritis	Yes	No	**Type:** _____
JOINT REPLACEMENT	**Yes**	**No**	If yes, what joint(s): _____

Date of joint replacement surgery? _____

LATEX SENSITIVITY **Yes** **No**
Recurrent Illnesses Yes No
If yes, please explain: _____

_____

If there are **any** other medical conditions, infections, and health problems that are not listed above, please explain: _____

_____

_____

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

Local anesthetics	Yes	No	
Antibiotics	Yes	No	**SPECIFY:** _____
Aspirin	Yes	No	
Codeine, Valium or other sedatives	Yes	No	**SPECIFY:** _____

Please list any other allergies or drug sensitivities:

_____

_____

Are you allergic or have you had a reaction to Iodine? Yes No

Do you have a chemical dependency? (Ex. Recreational drugs, alcohol, etc.)
_____
Are you a smoker? (Indicate cigarettes, cigars, pipes) _____
If so, how much do you smoke per day? _____
Do you use any other tobacco products? (Ex. smokeless tobacco, chewing tobacco).
Please indicate type: _____

Women Only: Are you pregnant?	Yes	No
If no, are you planning pregnancy?	Yes	No
Are you a nursing mother?	Yes	No
Using any pharmaceutical birth control?	Yes	No
If yes, what type? _____		

Everyone:

Do you wake up with a dry mouth?	Yes	No
Do you wake up with a headache?	Yes	No
Do you clench or grind your teeth?	Yes	No
Are you aware or have you been told that you have a tendency for snoring?	Yes	No
Do you wake in the morning feeling refreshed?	Yes	No
Have you ever been told that you stop breathing during sleep?	Yes	No

More questions on the back>>>>>>>>>>>>>

Please list **any** medication you are currently taking and what you are taking it for:

_____

_____

_____

_____

We want you to get the most benefit you can from your medicine.
Would you like a summary of useful information for the medications you listed above? Yes No

Have you ever been treated with any long-term antibiotic medicines? Yes No
If yes, please provide name of antibiotic: _____

Do you take Antacids? Yes No How often: _____
Do you or have you experienced excess stomach acid? Yes No
Are you taking any vitamins, herbal supplements/medications? Yes No
If yes, please list: _____

_____

Are you on a restricted diet? Yes No
If yes, please describe: _____
How many meals do you eat a day? _____
Do you have any food Allergies? Please list: _____

_____

Amount of sugar in your diet: None Slight Moderate High

Amount of sodium in your diet: None Slight Moderate High

Are there any prior dental office experiences you would like to share with us? Yes No
Is there anything you would like us to know about your dental health?

_____

Do you have any questions about your teeth?

_____

Please add any information you feel is important for us to know:

_____

Signature: _____

For Doctor's use only:
Comments on patient interview concerning medical history: _____
_____
Significant findings from questionnaire or oral interview: _____
_____
Dental management consideration: _____