Laurelwood Dental

Adult Health Questionnaire

Today's Date: ____________________

Patient name: ____________________

Date of birth: ____________________

The purpose of the following questions is to determine if you have a medical condition that may require special care. All information is confidential and kept in your dental record.

Name of physician: ________________________________ Physician phone: ____________________

Are you allergic to any of the following? (Check any that apply)

YES	NO		YES	NO		YES	NO	
☐	☐	LATEX RUBBER	☐	☐	SULFA	☐	☐	PENICILLIN
☐	☐	IODINE	☐	☐	ASPIRIN	☐	☐	CODEINE
☐	☐	DENTAL ANESTHETICS						

YES	NO	
☐	☐	Are you allergic to other medicines not listed? If yes, please list: ____________________
☐	☐	Are you allergic to any foods or substances? If yes, please list: ____________________

YES	NO	
☐	☐	Are you taking any prescription, over-thecounter, or herbal medicines? Please list: ____________________
☐	☐	Are you being treated by a physician now?
☐	☐	Have you ever been treated with biphosphonate medications?
☐	☐	Have you ever had any injuries to your face or jaw?
☐	☐	Alcoholic drinks: _______ per week
☐	☐	Cigarettes: _______ packs per day, years smoked _______

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

YES	NO	YEAR	CARDIOVASCULAR
☐	☐	_______	HEART ATTACK
☐	☐	_______	BLEEDING DISORDER
☐	☐	_______	PACEMAKER
☐	☐	_______	HEART DISEASE
☐	☐	_______	HIGH BLOOD PRESSURE
☐	☐	_______	HISTORY OF ENDOCARDITIS
☐	☐	_______	ARTIFICIAL HEART VALVE
☐	☐	_______	CONGENITAL HEART DEFECT
			NERVOUS SYSTEM
☐	☐	_______	STROKE
☐	☐	_______	CONVULSIONS/SEIZURES
☐	☐	_______	ADD/ADHD
☐	☐	_______	DEPRESSION

YES	NO	YEAR	PULMONARY
☐	☐	_______	ASTHMA
☐	☐	_______	TUBERCULOSIS
☐	☐	_______	COPD
			IMMUNE SYSTEM
☐	☐	_______	HIV POSITIVE
☐	☐	_______	CANCER
☐	☐	_______	RADIATION THERAPY
☐	☐	_______	CHEMOTHERAPY
☐	☐	_______	ORAL HERPES
☐	☐	_______	ARTHRITIS
☐	☐	_______	LUPUS
☐	☐	_______	SJOGREN'S DISEASE
☐	☐	_______	ORGAN TRANSPLANT

YES	NO	YEAR	ENDOCRINE
☐	☐	_______	DIABETES
☐	☐	_______	THYROID DISORDER
			HEPATORENAL
☐	☐	_______	KIDNEY DIALYSIS (A-V SHUNT)
☐	☐	_______	HEPATITIS B OR C
☐	☐	_______	KIDNEY/LIVER DISEASE
			MISCELLANEOUS
☐	☐	_______	ARTIFICIAL JOINTS
☐	☐	_______	DRY MOUTH
☐	☐	_______	UNEXPLAINED FEVER
☐	☐	_______	UNEXPLAINED WEIGHT LOSS
☐	☐	_______	DRUG/ALCOHOL DEPENDENCY
☐	☐	_______	ULCERS

☐ ☐ IF FEMALE, ARE YOU PREGNANT? DUE DATE ____________

☐ ☐ IS THERE ANYTHING ELSE THAT YOU THINK WE SHOULD KNOW? IF YES, PLEASE EXPLAIN: ____________________

I HAVE ANSWERED THESE QUESTIONS TO THE BEST OF MY KNOWLEDGE AND ABILITY.

I give consent for the administration of local anesthetics which are commonly used in dentistry to prevent pain. Risks of local anesthetic include allergic reactions, fainting, infection, hematoma (deep bruising, swelling and discoloration), and prolonged or permanent numbness. I have had the opportunity to discuss this with my dentist and may revoke this consent at any time.

X ____ ____________________

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE