Adult Health History

Patient Name: _____ Patient's Nickname: _____

Date of Birth:_____Gender: M F Patient's Email Address:_____

Patient's Address: _____

Name of Patient's Physician: _____ Physician's Phone #:_____

Who may we thank for referring you?_____Other family members seen by us:_____

Previous/Present Dentist:_____

Parent's Marital Status: Single Married Divorced

—PRIMARY DENTAL INSURANCE:

Insurance Name:_____ Ins. Company Phone #:_____

Insurance Company Address: _____

Group Policy Number:_____ Insured's Name:_____

Relationship to Patient:_____Insured's DOB: _____

Insured's Employer:_____ Orthodontic Coverage: Yes No

Social Security Number:_____

THE REASON FOR TODAY'S APPOINTMENT:

What does concern you about your teeth:_____
Have you ever had a serious/difficult problem associated with dental work? Yes No
Is your water fluoridated? Yes No
Have you ever had any pain or tenderness in the jaw joint (TMD/TMJ)? Yes No
Do you brush your teeth daily? Yes No
Do you floss your teeth daily? Yes No

A) PLEASE CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question):

1. Yes No Is your general health good?
2. Yes No Were you born prematurely? If YES, How many weeks?_____
3. Yes No Have you ever been hospitalized or had surgery?
   If Yes, explain_____
4. Yes No Are you being treated by a physician now? Date of last medical exam:_____
   If YES, for What?_____
5. Yes No Do you take any medicine/medications? (e.g. Prescription/Over the counter/herbal)
   If YES, what?_____
6. Yes No Do you have any allergies to drugs, food, other (e.g. LATEX)?
   If YES, Please explain type/severity of reaction?_____
7. Yes No Have you had problems with prior dental treatment? Date of Last dental exam:_____
   If YES, Please explain:_____
8. Yes No Are you in pain now or having a problem with your teeth?_____

B) DO YOU HAVE OR HAVE HAD:

9.	Yes	No	Asthma or trouble breathing?	20.	Yes	No	High blood pressure?
10.	Yes	No	Ear aches or ear problems?	21.	Yes	No	Cystic fibrosis?
11.	Yes	No	Hearing problems?	22.	Yes	No	Ulcers or stomach problems?
12.	Yes	No	Eye problems?	23.	Yes	No	Eating disorder/unusual diet?
13.	Yes	No	Speech problems?	24.	Yes	No	Hepatitis, jaundice, liver disease?
14.	Yes	No	Sinus problems?	25.	Yes	No	Extreme Weight Loss or gain?
15.	Yes	No	Cleft lip/cleft palate?	26.	Yes	No	Prolonged diarrhea?
16.	Yes	No	Apnea/Snoring?	27.	Yes	No	Bladder or kidney problems?
17.	Yes	No	Heart murmur or other heart problems?	28.	Yes	No	Arthritis or joint problems?
18.	Yes	No	Rheumatic fever or rheumatic heart disease?	29.	Yes	No	TMJ OR jaw joint problems?
19.	Yes	No	Skin problems?(e.g. eczema, hives, impetigo)	30.	Yes	No	Scoliosis or spine problems?

C) DO YOU HAVE OR HAVE HAD:

31.	Yes	No	Fainting or dizziness?	38.	Yes	No	Psychiatric treatment?
32.	Yes	No	Autism?	39.	Yes	No	Diabetes/high blood pressure?
33.	Yes	No	developmental delays or growth delays?	40.	Yes	No	Thyroid Problems?
34.	Yes	No	Learning disorders?	41.	Yes	No	Anemia
35.	Yes	No	Attention deficit/hyperactivity disorder(ADHD)?	42.	Yes	No	Blood disorder or transfusion?
36.	Yes	No	Mental problems or behavior disorders?	43.	Yes	No	Excessive bleeding/hemophilia?
37.	Yes	No	Brain and head injury?	44.	Yes	No	Sickle Cell disease or trait?

D) DO YOU HAVE OR HAVE HAD:

45.	Yes	No	Cerebral palsy?	50.	Yes	No	Cancer or tumor?
46.	Yes	No	Epilepsy, convulsions or seizures?	51.	Yes	No	Immune Disorder?
47.	Yes	No	Headaches or migraines?	52.	Yes	No	Chemotherapy ?
48.	Yes	No	Hydrocephaly or shunts?	53.	Yes	No	HIV/AIDS?
49.	Yes	No	Radiation treatment? Please list to what parts of the body and when _____				

E) DO YOU OR HAVE YOU EVER HAD:

54.	Yes	No	Smoke tobacco	56.	Yes	No	Use recreational drugs?
55.	Yes	No	Chew tobacco	57.	Yes	No	Use Alcohol?

F) FEMALE PATIENTS ONLY:

58.	Yes	No	Are you taking birth control pills?	59.	Yes	No	Could you be pregnant?

H) ALL PATIENTS:

60. Yes No Do you have or ever had any other diseases, medical problems NOT listed on this form?
If YES, please explain:_____

—To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Hanachi's offic of any change in my health and/or medication.

—I also authorize Dr. Hanachi's staff to perform the necessary dental services I may need.

Patient's signature:_____ Date:_____