Somerset
Dental Associates
Come smile with us!

1590 North Center Avenue, Suite 102 • Somerset, PA 15501
865 Eisenhower Boulevard, Complex 2 • Johnstown, PA 15904
814.444.0850

MEDICAL HISTORY-ADULT

Patient Name
(Please Print):_____ **Date of Birth**:_____

____Allergy Latex	____Venereal Disease	____Tumors/Growths
____ADD/ADHD	____AIDS/HIV	____Angina
____Artificial Heart Valve	____Anemia	____Artificial Joints
____Asthma	____Arthritis	____Blood Disease
____Cancer	____Autism	____Dental Complications
____Diabetes	____Cerebral Palsy	____Downs Syndrome
____Emphysema	____Dizziness	____Excessive Bleeding
____Fainting	____Epilepsy	____Glaucoma
____Head Injuries	____High Cholesterol	____Heart Disease
____Heart Murmur	____Headaches	____Hepatitis
____High Blood Pressure	____Heart Problems	____Lung Disease
____Kidney Disease	____Jaundice	____Nervous/Mental Disorder
____Malignant Hyperthermia	____Liver Disease	____Pre-Medicate
____Pacemaker	____Mitral Valve Prolapse	____Respiratory Problems
____Pregnancy	____Parkinson's Disease	____Shortness of Breath
____Rheumatic Fever	____Radiation Treatment	____Smoke/Chew
____Seizures	____Rheumatism	____Thyroid Problems
____Stomach Problems	____Sinus Problems	____Ulcers
____Tuberculosis	____Stroke	____Allergy Metal

1. **Do you have any drug allergies?** YES NO **If yes, please list:**

_____

_____

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2. Name of family physician.

_____

3. Are you taking any medications at this time? YES NO If yes, please list or present a copy of your medications.

_____

_____

4. Are you in good health? YES NO

5. Has there been any change in your health in the last year? YES NO

6. Are you under the care of a physician? YES NO If yes, for what condition?

_____

7. Have you had any serious illness, operations or been hospitalized in the past five years? YES NO
If yes, for what condition?

_____

8. Can you walk up a flight of stairs without stopping to rest? YES NO

9. Do you get short of breath easily? YES NO

10. Do your ankles swell? YES NO

11. Do you have an irregular heart rhythm? YES NO

12. Has your physician ever told you to take antibiotics prior to dental visits? YES NO If yes, for what condition?

_____

13. Do you currently have a cold, flu, runny nose, cough, or congestion of the head or chest? YES NO

14. Do you smoke? YES NO If yes, for how long?_____ How often?_____

15. Do you use chewing Tobacco? YES NO If yes, for how long?_____ How often?_____

16. Have you ever used illegal drugs? YES NO
(This is strictly confidential and for your medical safety)

17. Do you drink alcohol? YES NO If yes, how often? _____

18. Do you consume energy drinks? YES NO If yes, how often?_____

19. Do you have any bleeding disorders? YES NO

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20. Have you had surgery or radiation for a tumor/growth of your head or neck? YES NO

21. Have you ever had any serious trouble related to dental treatment? YES NO

22. Have you or anyone in your family had adverse reactions to anesthesia? YES NO

23. Do you snore heavily or have sleep apnea? YES NO

24. Do you have any condition not previously mentioned? YES NO If yes, please describe.

_____

25. Are you currently on or previously taken Fosamax or any Bisphosphonates for osteoporosis? YES NO

26. Is there any possibility that you may be pregnant? YES NO

27. Are you nursing (breast feeding)? YES NO

28. What pharmacy to you use and where is it located?

_____

29. How were you referred to our office? _____

30. Race (please check all that apply)

___African American ___Asian ___Alaskan Native ___Hispanic ___White

___Native American ___Native Hawaiian ___Other Pacific ___Other

___ I refuse to answer

I understand that withholding any information about my health could seriously jeopardize my safety. I have reviewed this health history form carefully and have answered all the questions truthfully to the best of my knowledge.

Patient Signature:_____

If under age 18,
Parent/Guardian name (please print):

_____

Parent/Guardian Signature:_____

Date:_____