Dr. Abby Neville

NEVILLE Dental Care

Adult Health History Information

Welcome to Neville Dental Care. We appreciate the confidence you place with us to provide dental services. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Name_____ Date_____

MEDICAL HISTORY

1. Has there been any change in your general health within the past year? Y N
   Your last physical exam was on _____
2. The name and address of your physician is _____
   _____
3. Have you had any serious illness, operation, or have been hospitalized in the past 5 years? Y N
   If so, what was the reason?_____
4. Please list all medications and supplements you are currently taking:
   _____
   If you take Bisphosphonates (e.g. Fosamax or Boniva): oral_____ IV_____
5. Are you allergic or react abnormally to any of the following:

Penicillin	Y	N	Tetracycline	Y	N	Erythromycin	Y	N
Codeine	Y	N	Local Anesthetics	Y	N	Sulfa	Y	N
Barbiturates	Y	N	Latex	Y	N			
Aspirin	Y	N	Other _____					

6. Do you require pre-medication prior to dental treatment? Y N
   If yes, for what reason? _____
7. Do you have, or have you had, any of the following?

Cardiovascular disease	Y	N	Congenital heart defects	Y	N			
Coronary occlusion	Y	N	Rheumatic valvular damage	Y	N			
Heart attack	Y	N	Angina	Y	N	Coronary insufficiency	Y	N
Mitral valve prolapse	Y	N	High blood pressure	Y	N	Stroke	Y	N
Cardiac pacemaker	Y	N	Heart murmur	Y	N	Artificial heart valves	Y	N

8. Do you smoke cigarettes? Y N If so, how much per day?_____
9. Do you have any contagious, sexually-transmitted or transmissible disease?

Hepatitis, Jaundice, Liver disease	Y	N	Aids/HIV infection	Y	N
Tuberculosis	Y	N	Other _____		

10. Do you have, or have you had, any of the following?

Cancer	Y	N	Kidney disease	Y	N	Prolonged bleeding	Y	N
Epilepsy	Y	N	Seizures	Y	N	Fainting spells	Y	N
Ulcers	Y	N	Thyroid disease	Y	N	Radiation	Y	N
Diabetes	Y	N	Mental health disorder	Y	N	Artificial joints	Y	N
Bloody sputum	Y	N	Anorexia	Y	N	Persistent cough	Y	N

11. Women: Are you pregnant/trying? Y N Due Date:_____ Taking oral contraceptives? Y N

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DENTAL HISTORY

1. When was your last dental visit? _____
2. For what reason _____
3. How often did you visit the dentist before then? _____
4. How often do you brush your teeth? _____
5. How often do you floss your teeth? _____
6. Is your drinking water fluoridated? Y N
7. Do your gums bleed while brushing or flossing? Y N
8. Are your teeth sensitive to hot or cold liquids/foods? Y N
9. Are your teeth sensitive to sweet or sour liquids/foods? Y N
10. Do you feel any pain in any of your teeth? Y N
11. Do you have any sores or lumps in or around your mouth? Y N
12. Have you had any head, neck or jaw injuries? Y N
13. Have you ever experienced any of the following problems in your jaw?
    - Clicking Y N
    - Pain (joint, ear, side of face) Y N
    - Difficulty opening or closing Y N
    - Difficulty in chewing Y N
14. Do you have frequent headaches? Y N
15. Do you clench or grind your teeth? Y N
16. Have you noticed any loosening of your teeth? Y N
17. Does food tend to become caught between your teeth? Y N
18. Have you ever had periodontal treatment (gums)? Y N
19. Have you ever worn a bite plate or night guard? Y N
20. Do you wear dentures or partials? Y N
21. If yes, date of placement_____
22. If you could change anything about your smile, what would you change?

    _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian

_____

Notes:

_____

_____

_____

Doctor's Initials_____ Date_____