Nevada Health Centers, Inc.
ADULT DENTAL HEALTH HISTORY QUESTIONNAIRE

Patient Name: _______________________________ DOB: ____________ Today’s Date: ____________

Please answer ALL of the following questions:

   Yes  No
□ □ Have you had an unexplained gain or loss of weight in the past 6 months? How much? ________________
□ □ Have you ever been treated for cancer? Date:_____ Location:____________ Outcome: ________________
□ □ Have you ever had radiation treatment? Date:_____ Location:____________ Outcome: ________________
□ □ Have you ever used intravenous drugs?
□ □ Have you used meth, cocaine or “crack” within the past 6 months?
□ □ Do you actively engage in high risk behavior for infectious diseases (e.g. AIDS, hepatitis)?

Do you have or have ever had:

   Yes  No
□ □ High blood pressure (hypertension)
□ □ Rheumatic heart disease or fever
□ □ Congenital heart disease/heart murmur
□ □ Heart attack or other heart problem
□ □ Artificial heart valve or pacemaker
□ □ Stroke
□ □ Epilepsy or seizures
□ □ Emphysema
□ □ Asthma
□ □ Lung disease or respiratory problems
□ □ Tuberculosis (TB)
□ □ Shortness of breath upon mild exertion
□ □ Hepatitis or other liver disease
□ □ Kidney disease
□ □ Diabetes or been frequently thirsty
□ □ Anemia/denied permission to give blood
□ □ AIDS or ARC (AIDS Related Complex)
□ □ Positive blood test for HIV antibodies
□ □ Venereal disease
□ □ Recent or unusual headaches
□ □ Currently under psychiatric care
□ □ Artificial bone/joint replacement or implants
□ □ Cardiac or vascular surgery
□ □ Head or neck surgery or trauma
□ □ Facial injuries or abnormalities
□ □ Other surgeries (specify):

Do you have or have ever had:

   Yes  No
□ □ Bleeding problems when tooth pulled
□ □ Blisters/sores on lips or mouth
□ □ Recent toothache or sensitivity
□ □ Do you smoke? #Packs/Day ________________
□ □ Do you use smokeless tobacco (chew)?

WOMEN ONLY:

□ □ Are you pregnant? Due Date ________________
□ □ Do you take birth control pills?
□ □ If pregnant, has your doctor cleared you for any possible dental work needed?

ALLERGIES: Have you been allergic to or had a bad reaction to:

□ □ Penicillin
□ □ Sulfamethoxazole (Sulfa Drugs)
□ □ Dental Anesthetics (local anesthetics)
□ □ Nitrous Oxide Analgesia (laughing gas)
□ □ Aspirin
□ □ Codeine
□ □ Tranquilizers (Valium, Vistaril, Atarax)
□ □ Metals (rings/earrings)
□ □ Other (specify): ____________________________________________________________

Please explain any “Yes” answers:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Origionation 7/21/10 | Revised 10/16/19 (Replaces MR5.03Fc)
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List all prescription and non-prescription drugs (including aspirin) that you are currently taking or have taken recently:
1. ____________________________ 3. ____________________________ 5. ____________________________
2. ____________________________ 4. ____________________________ 6. ____________________________

Have you had any unpleasant experiences in a dental office?  ☐ Yes  ☐ No

Is there anything else about your health we should know? ____________________________________________________________

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. If my health or medications change, I will inform clinic personnel at my next appointment.

Patient or Legal Guardian’s Signature ____________________________________________________________ Date ________________

Relationship to Patient ___________________________________________ Date ________________

Witness Signature ___________________________________________ Date ________________

______________________________________________________________________________

HEALTH HISTORY COMMENTS & UPDATES (TO BE COMPLETED BY CLINICIAN)

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Provider Signature ___________________________________________ Date ________________