NEVADA HEALTH CENTERS

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
☐	☐	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:

_____

_____

_____

_____

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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 _____

Relationship to Patient _____ Date _____

Witness Signature _____ Date _____

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

_____

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Provider Signature _____ Date _____