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	
1	☐	☐	Have you had an unexplained gain or loss of weight in the past 6 months? How much? _____
2	☐	☐	Have you ever been treated for cancer? Date: _____ Location: _____ Outcome: _____
3	☐	☐	Have you ever had radiation treatment? Date: _____ Location: _____ Outcome: _____
4	☐	☐	Have you ever used intravenous drugs?
5	☐	☐	Have you used meth, cocaine or "crack" within the past 6 months?
6	☐	☐	Do you actively engage in high risk behavior for infectious diseases (e.g., AIDS, hepatitis)?

Do you have or have ever had:

	Yes	No	
7	☐	☐	High blood pressure (hypertension)
8	☐	☐	Rheumatic heart disease or fever
9	☐	☐	Congenital heart disease/heart murmur
10	☐	☐	Heart attack or other heart problem
11	☐	☐	Artificial heart valve or pacemaker
12	☐	☐	Stroke
13	☐	☐	Epilepsy or seizures
14	☐	☐	Emphysema
15	☐	☐	Asthma
16	☐	☐	Lung disease or respiratory problems
17	☐	☐	Tuberculosis (TB)
18	☐	☐	Shortness of breath upon mild exertion
19	☐	☐	Hepatitis or other liver disease
20	☐	☐	Kidney disease
21	☐	☐	Diabetes or been frequently thirsty
22	☐	☐	Anemia/denied permission to give blood
23	☐	☐	AIDS or ARC (AIDS Related Complex)
24	☐	☐	Positive blood test for HIV antibodies
25	☐	☐	Venereal disease
26	☐	☐	Recent or unusual headaches
27	☐	☐	Currently under psychiatric care
28	☐	☐	Artificial bone/joint replacement or implants
29	☐	☐	Cardiac or vascular surgery
30	☐	☐	Head or neck surgery or trauma
31	☐	☐	Facial injuries or abnormalities
32	☐	☐	Other surgeries (specify):

_____

_____

_____

_____

Do you have or have ever had:

	Yes	No	
33	☐	☐	Bleeding problems when tooth pulled
34	☐	☐	Blisters/sores on lips or mouth
35	☐	☐	Recent toothache or sensitivity
36	☐	☐	Do you smoke? #Packs/Day _____
37	☐	☐	Do you use smokeless tobacco (chew)?

WOMEN ONLY:

38	☐	☐	Are you pregnant? Due Date _____
39	☐	☐	Do you take birth control pills?
40	☐	☐	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:

41	☐	☐	Penicillin
42	☐	☐	Sulfa Drugs
43	☐	☐	Dental Anesthetics (local anesthetics)
44	☐	☐	Nitrous Oxide Analgesia (laughing gas)
45	☐	☐	Aspirin
46	☐	☐	Codeine
47	☐	☐	Tranquilizers (Valium, Vistaril, Atarax)
48	☐	☐	Metals (rings/earrings)
49	☐	☐	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:

DRUG NAME	DOSAGE	FREQUENCY

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 Signature: _____

Relationship to Patient: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

OFFICE USE ONLY

Health History Comments & Updates

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PROVIDER Signature: _____ **Date:** _____