

ARRICK AND ASSOCIATES
601 Tucker Street
Raleigh, NC 27603
(919) 833-8100
ADULT HEALTH HISTORY QUESTIONNAIRE

Full Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Telephone (home) _____ (work) _____ (other) _____

Sex _____ Age _____ Race _____ Height _____ Weight _____ Marital Status _____

Occupation _____ Employer _____

Social Security Number _____ Driver's License Number _____

Spouse's Name _____ Spouse's Employer _____

Spouse's Social Security Number _____ Spouse's Date of Birth _____

EMERGENCY CONTACT NAME _____ **PHONE NUMBER** _____

**OUR OFFICE POLICY REQUIRES THAT PAYMENT BE MADE AS SERVICES ARE RENDERED
UNLESS PRIOR ARRANGEMENTS ARE MADE.**

Method of Payment: Cash _____ VISA/MC/ATM _____ DISCOVER _____ Insurance _____ Electronic Check _____

How were you referred to our office? Yellow Pages _____ Friends Name _____ CitySearch _____

***Insurance deductible must be met and any part of the fee not covered by your insurance **MUST BE PAID** on the day services are rendered.

THE FOLLOWING QUESTIONS PERTAIN TO YOUR MEDICAL HISTORY AND THE ANSWERS ARE IMPORTANT, BECAUSE THEY HELP US DETERMINE THE BEST POSSIBLE DENTAL TREATMENT FOR YOUR SITUATION. ALL INFORMATION GIVEN WILL REMAIN STRICTLY CONFIDENTIAL. PLEASE ANSWER ALL QUESTIONS HONESTLY. PLEASE **CIRCLE** YES OR NO.

1. Have you ever been seriously ill or had a major operation? YES NO
2. Are you presently being treated by a medical doctor for any Condition? If so what for? YES NO

3. List your medications? _____

4. Have you ever had to take antibiotics before having dental work? YES NO
5. Do you have any artificial joints or artificial heart valves? YES NO
6. Do you have chest pain upon exertion? YES NO
7. List your **Medication Allergies: Latex?**

8. Have you or do you suspect that you have ever been in contact with the AIDS (HIV) virus? YES NO

(OVER)

9. Would you consent to a blood test (at our expense) if the Doctor or staff member suffers a needle stick or puncture wound? YES NO

FOR WOMEN ONLY:

Are you pregnant?	YES	NO
Are you taking oral contraceptives (birth control pills)	YES	NO

10. Have you ever experienced an unusual reaction to dental anesthetic? YES NO

11. Have you ever had a bad dental experience? YES NO

12. Have you had or have you been told that any of the following pertain to you?

Mitral valve prolapse	YES	NO	Rheumatic fever	YES	NO
Heart Murmur	YES	NO	Hepatitis	YES	NO
High Blood Pressure	YES	NO	Tuberculosis	YES	NO
Diabetes	YES	NO	Stroke	YES	NO
Heart Attack	YES	NO	Liver Problems	YES	NO
Asthma/hay fever	YES	NO	Venereal Disease	YES	NO
Hives/Skin Rash	YES	NO	Kidney Disease	YES	NO
Epilepsy/seizures	YES	NO	Cancer	YES	NO
Anemia	YES	NO	Substance Abuse	YES	NO
AIDS/HIV	YES	NO	Other	YES	NO

13. Do you bleed for a long time when/if you cut yourself? YES NO

14. Have you gained or lost weight in the last few months? YES NO

15. Have you taken FEN PHEN or Bisphosphonate. Please **Circle** (Fosamax, Skelid, Actonel, Didronel, Boniva, Areda, Zometa, and Bonefos)? YES NO

16. Are You a Smoker? YES NO

DENTAL HISTORY

1. When was the last time you had your teeth cleaned? _____

2. Do you have fluoride in your drinking water? YES NO

3. Have you ever had periodontal (gum) treatment? YES NO

4. Have you ever had orthodontic treatment (braces)? YES NO

5. Do you use a soft, medium, or hard toothbrush? _____

6. Do you floss or use any other daily aids, as you should? YES NO

7. Do your gums bleed when you brush or floss? YES NO

WOMEN WHO TAKE ORAL CONTRACEPTIVES SHOULD TAKE EXTRA PRECAUTIONS WHEN TAKING ANTIBIOTICS, BECAUSE ANTIBIOTICS CAN CAUSE FAILURE OF THE BIRTH CONTROL PILLS AND YOU COULD BECOME PREGNANT.

I have read and understand the above questions. I have answered all of these to the questions truthfully to the best of my ability and knowledge. I consent to any use of intraoral pictures for educational purposes.

SIGNATURE _____ DATE _____

UPDATES

Date Initials PR/PT

Changes

