Dr. Mark Olivito & Associates
HEALTH HISTORY FORM – ADULT

Date: _________________ Name: _______________ __________________ DOB: _________________
DD MMM YYYY FIRST LAST DD MMM YYYY
Address:_____________________________________ Phone:________________________ Gender: F☐ M ☐

Email Address:____

1. Physician:______________________________ Location:__________________
   Are you under the care of a physician and/or a medical specialist? *If yes, please explain…* Y☐ N ☐
   Specialist:______________________________ Location:__________________
   ____
   ____
   ____
2. Have you ever been hospitalized overnight? ____ Y☐ N ☐
3. What is your pharmacy of record? ____
4. Have you recently, or are you presently taking any prescription or non-prescription medications, vitamins or supplements? If yes, please list medications below OR attach a list of medications. Y☐ N ☐
   ____
   ____
   ____
5. Have you ever had any adverse or unusual reaction to any medications/injections or been advised against taking any specific type of medications? (Penicillin, Sulpha, Aspirin, Codeine, Local anesthetic/freezing, Nitrous Oxide or any other medications. If yes, please explain. Y☐ N ☐
   ____
6. Do you have any of the following?
   Asthma ________________________ Y☐ N ☐ Hay Fever ________________________ Y☐ N ☐
   Food Allergies ___________________ Y☐ N ☐ Metal/Latex Allergy ________________ Y☐ N ☐
   Skin Rashes _____________________ Y☐ N ☐ Hives _____________________________ Y☐ N ☐
   Any other Allergic Condition ____ Y☐ N ☐
7. Is there a family history of Diabetes, Cancer or Heart Disease? ______________________ Y☐ N ☐
8. Do you bleed excessively from a cut or injury? __________________________________ Y☐ N ☐
9. Do you bruise easily? ____ Y☐ N ☐
10. Do you ankles, feet or hands swell on a regular basis? ____________________________ Y☐ N ☐
11. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? Y☐ N ☐
12. Have you ever had trauma to your face or jaw? _________________________________ Y☐ N ☐
13. Do you have any head, neck or back issues/injuries?_____________________________________ Y☐ N ☐
14. Have you ever fainted during dental or medical treatment? ________________________ Y☐ N ☐
15. Do you wear eye glasses? Y☐ N ☐ Contact lenses? Y☐ N ☐
16. Do you have any hearing difficulties? _______________________________________ Y☐ N ☐
17. Do you smoke, vape or use cannabis for recreational or medicinal purposes? Y☐ N ☐
    ____
18. Are you alcohol or drug dependent or have you ever received treatment for dependency? Y☐ N ☐
    ____
19. Do you have anxiety, depression or any other mental health concerns? Y☐ N ☐
    *If yes, have you ever received or are you currently receiving treatment?*______________________________

20. Have you ever had any form of cancer?____________________________ Y☐ N ☐
If yes, did you receive radiation or chemotherapy treatments?__________ When?_________

21. Please indicate which of the following your presently have or have ever had:

ADHD Y☐ N ☐
AIDS/HIV Y☐ N ☐
Anemia Y☐ N ☐
Anxiety/Depression Y☐ N ☐
Arthritis Y☐ N ☐
Artificial Joint Y☐ N ☐
☐ *Hip ___*
☐ *Knee____*
☐ *Other___*
Celiac Disease Y☐ N ☐
Cerebral Palsy Y☐ N ☐
Circulation Problems Y☐ N ☐
Crohn's/Colitis/IBS Y☐ N ☐
Cortisone/Steroid Therapy Y☐ N ☐
Diabetes Y☐ N ☐
Eating Disorder Y☐ N ☐
Epilepsy or Seizures Y☐ N ☐
Fibromyalgia Y☐ N ☐
Glaucoma Y☐ N ☐

Heart Issue(s) Y☐ N ☐
☐ *Heart Disease*
☐ *Heart Murmur*
☐ *Heart Rhythm Disorder*
☐ *Heart Surgery_________*
☐ *Angina*
☐ *Mitral Valve Prolapse*
☐ *Other___________*
Hepatitis ☐ A ☐ B ☐ C Y☐ N ☐
Herpes/Cold Sores Y☐ N ☐
☐ High/ ☐ Low Blood Pressure Y☐ N ☐
Kidney Disease Y☐ N ☐
Liver Disease Y☐ N ☐
Lung Disease/COPD/Emphysema Y☐ N ☐
Lupus Y☐ N ☐
Malignant Hypothermia Y☐ N ☐
Migraines Y☐ N ☐
MS (Multiple Sclerosis) Y☐ N ☐
Organ Transplant ________ Y☐ N ☐
Scarlett Fever/Rheumatic Fever Y☐ N ☐

Shingles Y☐ N ☐
Sickle Cell Disease Y☐ N ☐
Sinus Issues Y☐ N ☐
Speech Disorder Y☐ N ☐
Stroke/TIA _____ Y☐ N ☐
Thyroid Disease Y☐ N ☐
Tinnitus Y☐ N ☐
Tuberculosis Y☐ N ☐
Ulcers (H Pylori) Y☐ N ☐
Venereal Disease Y☐ N ☐
Vertigo/Dizzy Spells Y☐ N ☐

OTHER:
____
____
____
____

22. In the past 12 months have you a Heart Attack? Y☐ N ☐ Stroke Y☐ N ☐ TIA? Y☐ N ☐
____

23. WOMEN ONLY
Are you pregnant or suspect you may be? Y☐ N ☐ If so, expected due date? _______________
Are you breast feeding? Y☐ N ☐ Are you taking Birth Control Pills? Y☐ N ☐

24. Are there any other conditions/diseases regarding your health history that we should be made aware of? Y☐ N ☐
____

25. Do you wish to speak privately to the Doctor about any concern or medical condition? Y☐ N ☐

In the event of an emergency, please contact the following person on my behalf:

Name: ___________________________ Number:_______________ Relationship:________________

I, the undersigned, certify that I have provided an accurate and complete personal and health history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any any questions regarding my health history. Should there be any change in either my health status or any other information I have provided I will advise the dental office, and I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand the information provided from or to my medical doctor or other health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidance of the policy. I understand that responsibility for payment of the dental services for myself and dependents is mine, and I assume responsibility for fees associated with these services.

Signature: ____ Date: ______________
DD MMM YYYY