Dr. Brenda Taege, DDS, LLC
Cosmetic and General Dentistry

8416 East Shea Blvd.
Scottsdale, AZ 85260
480-860-6744

Adult Health History

PATIENT NAME____TELEPHONE____________________

1. Are you having pain or discomfort at this time? ___________________________________Yes/No
2. Do you feel nervous about having dental treatment? _______________________________Yes/No
3. Have you ever had a bad experience in a dental office? ____________________________Yes/No
4. Have you ever been under the care of a medical Doctor in the past 2 years? _______________Yes/No

   Physician's name____

   Address____

   ____

   Phone No.____

5. Are you currently taking any medication, drugs or pills? ______________________________Yes/No
6. Are you allergic or have you reacted adversely to any of the following medications?__________Yes/No

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Codeine	Erythromycin	Penicillin	Other (List) ______________________

7. Have you ever been a patient in a hospital? _______________________________________Yes/No
8. Circle any of the following that you have had or current have:

Heart Failure	Congenital Heart Lesions	Sinus Trouble	Yellow Jaundice
Stroke	Scarlet Fever	Allergies or Hives Diabetes	Blood Transfusion
Chemotherapy (Cancer, Leukemia)	Artificial Heart Valve	Thyroid Disease	Cold Sores
Hemophilia	Heart Pacemaker	Rheumatism	Fever Blisters
Heart Disease or Attack	Heart Surgery	Cortisone Medicine	Epilepsy or Seizures
Kidney Trouble	Artificial Joints (Hip. Knee)	Glaucoma	Fainting or Dizzy Spells
Arthritis	Ulcers	Pain in Jaw Joints	Nervousness
Venereal Disease (Syphilis. Gonorrhea)	Emphysema	AIDS	Psychiatric Treatment
Angina Pectoris	Cough Tuberculosis	Hepatitis A (infectious)	Bruise Easily
High Blood Pressure	(TB)	Hepatitis B (serum)	Anemia
Heart Murmur	Asthma	Liver Disease	X-Ray or Cobalt Treatment
Rheumatic Treatment	Hay Fever		Drug Addiction

9. Do you have any disease condition or problem not listed? ___________________________Yes/No

THE INFORMATION I HAVE JUST GIVEN IS TRUE.

Patient Name: ____*Date*:____________________

Guardian Signature: __________________________*Relationship to Patient*:____________________

MEDICAL UPDATE:

If information is still correct please sign and date here… Date_____/_____/______ Signature: ____________________

If information is still correct please sign and date here… Date_____/_____/_______Signature: ____________________

If information is still correct please sign and date here… Date_____/_____/_______Signature: ____________________