Adult Medical-Dental History

Adult Medical History

Medical Doctor _____ Phone Number _____

Have you been under the care of a Physician in the last 2 years? ◯ Yes ◯ No

If yes, please explain: _____

Have you been hospitalized or had any surgeries in the last 5 years? ◯ Yes ◯ No

If yes, please explain: _____

Have you had any adverse reaction to any medications or local anesthetic? ◯ Yes ◯ No

If yes, please explain: _____

Are you allergic to or had a bad reaction to Latex or Metals? ◯ Yes ◯ No

If yes, please explain: _____

Women: Are you pregnant? ◯ Yes ◯ No Due Date _____ Are you nursing? ◯ Yes ◯ No

Have you taken bone sparing drugs such as Fosamax, Actonel, Boniva or Zometa? ◯ Yes ◯ No

If yes, how long? _____

A1C # _____ Date last taken: _____ INR # _____ Date last taken: _____

Are you currently taking any medications? ◯ Yes ◯ No

Do you smoke or use tobacco products?

◯ Yes ◯ No Packs per day: _____ Cans per week _____ How many years? _____

Do you use alcohol?

◯ Yes ◯ No How often? _____

Emergency Contact _____ Relationship: _____ Phone _____

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Medical History- continued

Do you have or have you experienced the following? Please check all that apply to you.

- ☐ Abnormal Bleeding
- ☐ Alcohol Addiction
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Pins, Bones or Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Cancer/Tumors

List type: _____

- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes

List type: _____

- ☐ Difficulty Breathing
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing Problem
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery

List type: _____

- ☐ Hemophilia
- ☐ Hepatitis

List type: _____

- ☐ Herpes

List type: _____

- ☐ High Blood Pressure
- ☐ H.I.V. Positive or A.I.D.S.
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders

List type: _____

- ☐ Osteoporosis
- ☐ Pacemaker

Date Placed: _____

Type: _____

- ☐ Persistent Cough
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcers or Stomach Trouble
- ☐ Other _____

Please list any serious medical conditions(s) not indicated above that you have expeienced in the last 5 years:

Adult Medical-Dental History

Medications Currently Taking

Current medications you are taking:

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Medical History- authorization

Are you taking any of the following?

- ☐ Actonel
- ☐ Aredia
- ☐ Fosamax
- ☐ Nitroglycerin
- ☐ Tomaxafin
- ☐ Zometa
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Birth Control Pills
- ☐ Blood Pressure Medication
- ☐ Blood Thinners
- ☐ Osteoporosis Drugs, either in the past or currently taking
- ☐ Digitalis or Heart Medication
- ☐ Insulin or Diabetes Drugs
- ☐ Steroids or Cortisone
- ☐ Recreational Drugs
- ☐ Thyroid Medication

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Barbituates
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Penicillin
- ☐ Sedatives
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Other _____

Describe type of reaction: _____

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Adult Dental History

Previous Dentist Name _____ Phone Number _____

Address _____

Purpose of initial visit _____

Are you aware of any problems? _____

Date of last dental visit? _____ When was your last cleaning? _____

Were x-rays taken? ◯ Yes ◯ No Do your gums bleed or hurt? ◯ Yes ◯ No

How often do you brush? _____ How often do you floss? _____

History of gum surgery? ◯ Yes ◯ No If yes, when? _____

Removed or lost any teeth? ◯ Yes ◯ No If yes, why? _____

Any complications or problems with previous dental treatment? ◯ Yes ◯ No

If yes, explain: _____

Do you have any questions or concerns to talk to the doctor about? ◯ Yes ◯ No

Do you clench or grind your teeth? ◯ Yes ◯ No Any soreness or pain in your jaw? ◯ Yes ◯ No

Does your jaw lock or pop? ◯ Yes ◯ No Do you have frequent headaches? ◯ Yes ◯ No

Do you have any sensitive teeth? ◯ Yes ◯ No Does food get caught in your teeth? ◯ Yes ◯ No

Are you happy with the appearance of your smile? ◯ Yes ◯ No Have you had any orthodontic work? ◯ Yes ◯ No

Patient Signature

X _____

_____

Signer's Full Name Date