Adult Medical History

Patient's Name:_______________________________________ **Birth Date:** ____________________

Are you under a physician's care now? If yes, Explain ______________________________ Yes No

____

Physician's Name:________________________________ Phone #_________________________________

Have you ever had a serious injury to your head or neck? Explain _____________________ Yes No

____

Are you taking any medications, pills or drugs? If yes, please list all ____________________Yes No

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Women: Are you: ☐ Pregnant? Due Date:_____________☐ Taking oral contraceptives? ☐ Nursing?

Are you allergic to any of the following medication or substances? ☐ Aspirin ☐ Penicillin ☐ Metal ☐ Codeine ☐ Acrylic ☐ Latex ☐ Lidocaine ☐ Other:___________________________________

Do you now have or ever had any of the following?

AIDS	Yes	No		Yes	No
Alzheimer's disease	Yes	No	Hepatitis Type:_____	Yes	No
Anemia	Yes	No	Herpes	Yes	No
Angina/Chest pain	Yes	No	High blood pressure	Yes	No
Arthritis/ Rheumatism	Yes	No	HIV+	Yes	No
Artificial joints	Yes	No	Jaundice	Yes	No
Artificial valves	Yes	No	Jaw pain	Yes	No
Asthma	Yes	No	Kidney disease	Yes	No
Back problems	Yes	No	Liver disease	Yes	No
Bruise easily	Yes	No	Low blood pressure	Yes	No
Cancer	Yes	No	Mental disorder	Yes	No
Chemical dependency	Yes	No	Mitral valve prolapse	Yes	No
Chemotherapy	Yes	No	Nervous problems	Yes	No
Cortisone treatments	Yes	No	Pacemaker	Yes	No
Diabetes	Yes	No	Psychiatric care	Yes	No
Dialysis	Yes	No	Respiratory problems	Yes	No
Dizziness/Fainting	Yes	No	Rheumatic fever	Yes	No
Drug addiction	Yes	No	Seizures	Yes	No
Emphysema	Yes	No	Sinus problems	Yes	No
Epilepsy	Yes	No	Stomach problems	Yes	No
Excessive bleeding	Yes	No	Stroke	Yes	No
Growths/Tumors	Yes	No	Surgical implants	Yes	No
Hay fever	Yes	No	Thyroid disease	Yes	No
Head injuries	Yes	No	Tuberculosis	Yes	No
Heart problems:	Yes	No	Ulcers	Yes	No
(Describe)_________________________			Venereal disease	Yes	No
Heart murmur	Yes	No	Other:_______________________________		
If yes, do you need to be pre-medicated?			_____________________________________		

Dental History

What is your primary reason for this dental appointment? ☐ Examination ☐ Emergency

☐ Consultation ☐ Other: ____

Do you have a specific dental problem? Describe:______________________________ Yes No

Did you have dental examinations on a routine basis? Last visit: ____________________ Yes No

How many times a day do you brush your teeth?________________________________

How many times a day do you floss your teeth? ________________________________

Do your gums ever bleed, feel tender or irritated? ______________________________Yes No

Do you think or know that you have active decay or gum disease? ___________________Yes No

Are your teeth sensitive to any of the following? (please circle) Hot Cold Sweets Pressure

Do you like your smile? Why or why not?____________________________________ Yes No

Does food catch between your teeth? _______________________________________ Yes No

Do you want to keep your remaining teeth?___________________________________ Yes No

Do you ever have clicking, popping, or discomfort in the jaw joint?___________________ Yes No

Do you grind or clench your teeth during the night?____________________________ Yes No

Do you wear dentures or partials? ____ Yes No

Are you in orthodontic (braces) treatment at this time? __________________________ Yes No

Have you ever worn braces or an orthodontic retainer? __________________________ Yes No

Have your past experiences in a dental office always been positive? _________________ Yes No

Do you smoke or chew tobacco?____ Yes No

Do you have any sores or growths in your mouth? ______________________________ Yes No

Name of your previous dentist: __________________________ Phone # ____________________

Date of last full mouth x-rays or pano:____

Do you wish to talk to the dentist privately about any problems? ____________________Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or in my medications, I will inform the dentist and staff at my next dental appointment.

____ ____________________

Patient Signature **Date**