Adult Patient Medical History

Patient Name: _____ ***DOB*** _____

Current Address, City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Physician _____ Office phone _____ Date of Last Exam _____

Emergency Contact / Phone Number _____

Are you under medical care now?	❑ Yes	❑ No
Have you been hospitalized in the past 5 years?	❑ Yes	❑ No
Have you ever taken Fosamax, Boniva, Actonel or any medications for osteoporosis containing bisphosphonates?	❑ Yes	❑ No
Do you have a persistent cough not associated with a known illness (lasting more than 3 weeks)?	❑ Yes	❑ No
Do you use tobacco?	❑ Yes	❑ No
Do you / have you used controlled substances?	❑ Yes	❑ No
Are you taking any medications? (List on back if needed)	❑ Yes	❑ No
_____	____	_____
_____	____	_____

Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)	❑ Yes	❑ No
Narcotics (e.g. Codeine)	❑ Yes	❑ No
Penicillin or any other antibiotics	❑ Yes	❑ No
Sulfa drugs	❑ Yes	❑ No
Barbiturates	❑ Yes	❑ No
Sedatives	❑ Yes	❑ No
Iodine	❑ Yes	❑ No
Aspirin	❑ Yes	❑ No
Any metals (e.g. nickel, mercury, etc.)	❑ Yes	❑ No
Latex rubber	❑ Yes	❑ No
Other (please list) _____	❑ Yes	❑ No

Women only: Are you pregnant, nursing or think you may be pregnant? ❑ Yes ❑ No

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

Heart Trouble or Heart Disease	❑ Yes	❑ No	Leukemia	❑ Yes	❑ No	Sleep Apnea	❑ Yes	❑ No
High or Low Blood Pressure	❑ Yes	❑ No	Radiation Therapy	❑ Yes	❑ No	Stomach Troubles / Ulcers	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Chest Pains	❑ Yes	❑ No
Cardiac Pacemaker, Defibrillator	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	AIDS or HIV Infection	❑ Yes	❑ No	Hay Fever / Allergies	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No	Thyroid Problem	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Fainting / Seizures	❑ Yes	❑ No	Anemia	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No
Epilepsy / Convulsions	❑ Yes	❑ No	Arthritis	❑ Yes	❑ No	Recent Weight Loss	❑ Yes	❑ No
Asthma or Breathing Issues	❑ Yes	❑ No	Sexually Transmitted Disease	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Joint Replacement or Implant	❑ Yes	❑ No	Hepatitis / Jaundice	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	If yes, when? _____			Other: _____	❑ Yes	❑ No

Adult Patient Dental History

Do your gums bleed while brushing or flossing?	❑ Yes	❑ No
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑ Yes	❑ No
Are your teeth sensitive to hot or cold liquids/foods?	❑ Yes	❑ No
Are they sensitive to sweet or sour liquids/foods?	❑ Yes	❑ No
Do you feel pain in any of your teeth?	❑ Yes	❑ No
Do you have any sores or lumps in or near your mouth?	❑ Yes	❑ No
Have you had any head, neck or jaw injuries?	❑ Yes	❑ No
Have you experiences any of the following in your jaw?		
Clicking	❑ Yes	❑ No
Pain (joint, ear, side of face)	❑ Yes	❑ No
Difficulty opening or closing	❑ Yes	❑ No
Difficulty in chewing	❑ Yes	❑ No

Do you have frequent headaches?	❑ Yes	❑ No
Do you clench or grind your teeth?	❑ Yes	❑ No
Do you bite your lips or cheeks frequently?	❑ Yes	❑ No
Do you wear a TMJ splint or night guard?	❑ Yes	❑ No
Have you ever had any difficult extractions in the past?	❑ Yes	❑ No
Have you ever had any prolonged bleeding?	❑ Yes	❑ No
Pre-Med: Do you require antibiotic pre-medication prior to any dental treatment?	❑ Yes	❑ No
Have you had any periodontal (gum) treatment?	❑ Yes	❑ No
Have you had any orthodontic treatment?	❑ Yes	❑ No
Do wear dentures or partials?	❑ Yes	❑ No
Date of placement _____		
Do you like your smile?	❑ Yes	❑ No

Date of Last Dental Exam _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient (or parent/guardian) Date