Adult Medical History

Patient Name ______________________________ D.O.B. ______________

Emergency Contact (Name/Phone Number) ______________________________

Medical History

1. Physician______________________Address ______________________

2.When was your last physical examination? ______________________

3. Are you under the care of a physician?.. ☐ Yes ☐ No

If yes, for what reason(s)? ______________________

4. Are you presently taking any medications/drugs/pills/herbals/supplements?................ ☐ Yes ☐ No

If yes, please list:______________________

5. (Women) Is there a chance you are pregnant? .... ☐ Yes ☐ No

If yes, anticipated due date?______________________

6. Do you take oral contraceptives? .... ☐ Yes ☐ No

7. Are you allergic/sensitive to: ☐None ☐Codeine ☐Penicillin ☐Local Anesthetic ☐Latex ☐Pine Nuts ☐Dyes

☐ Other______________________

8. Do you smoke, chew or use E-cigarettes? .... ☐ Yes ☐ No

If yes, please indicate which one(s), daily frequency and how long?______________________

9. Do you have Diabetes? .... ☐ Yes ☐ No

If Yes, please indicate ....☐ Type 1 ☐ Type 2 Last HbA1c date and level______________

10. Do you have, or have you ever had:

Heart trouble .... ☐Yes ☐No

Heart murmur.. ☐Yes ☐No

Heart surgery.. ☐Yes ☐No

Heart pacemaker.. ☐Yes ☐No

Rheumatic fever .... ☐Yes ☐No

Congenital heart defects .... ☐Yes ☐No

Artificial heart valve/stent/graft............ ☐Yes ☐No

Abnormal blood pressure .... ☐Yes ☐No

Stroke.. ☐Yes ☐No

Ulcers / GERD.. ☐Yes ☐No

Kidney trouble/Dialysis .... ☐Yes ☐No

Tuberculosis or lung disease............... ☐Yes ☐No

Asthma.. ☐Yes ☐No

Sinus trouble.. ☐Yes ☐No

Epilepsy / seizures .... ☐Yes ☐No

Fainting spells.. ☐Yes ☐No

Anemia .... ☐Yes ☐No

Leukemia .... ☐Yes ☐No

Excessive or prolonged bleeding .... ☐Yes ☐No

Thyroid problem.. ☐Yes ☐No

Jaundice.. ☐Yes ☐No

Hepatitis(Type).. ☐Yes ☐No

Cancer.. ☐Yes ☐No

Chemotherapy/radiation .... ☐Yes ☐No

Arthritis .... ☐Yes ☐No

Artificial joint replacements .... ☐Yes ☐No

Cortico-Steroid treatment................................ ☐Yes ☐No

Osteoporosis/treatment w/Bisphosphonates ... ☐Yes ☐No

HIV positive/AIDS.. ☐Yes ☐No

Oral herpetic lesions .... ☐Yes ☐No

Sexually Transmitted disease .... ☐Yes ☐No

Psychiatric care.. ☐Yes ☐No

Glaucoma .... ☐Yes ☐No

Hearing impaired .... ☐Yes ☐No

Chemical dependency.. ☐Yes ☐No

Do you take pre-medication for anything........ ☐Yes ☐No

If you pre-medicate for what ______________________

11. Have you had any other serious illness, hospitalization or accident? ☐Yes ☐No

If yes, please explain:______________________

(OVER PLEASE)

Rev 2/15

Adult Medical History

Dental History

1. Former Dentist________________________ Address ________________________
2. When did you last visit a dentist?______________ When was your last cleaning? ______________
   X-rays taken? .... ☐ Yes ☐ No
   If yes: ☐ Full Mouth Series ☐ Bitewings ☐ Panoramic
   What was done at your last visit? ________________________
   Why did you leave that dentist? ________________________
   Has any dental treatment been recommended to you that you have not had done? ______________
3. Are you aware of any dental problems? .... ☐ Yes ☐ No
   Explain: ________________________
4. Please rate the present condition of your mouth. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
5. Have you ever been treated for gum disease? .... ☐ Yes ☐ No
   If yes, what was done?________________________
6. Do you have well water? .... ☐ Yes ☐ No
7. Is your water fluoridated? .... ☐ Yes ☐ No
8. Are your teeth sensitive to: ☐ Nothing ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure
9. Please rate the appearance of your smile. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
10. Would you like a whiter smile? .... ☐ Yes ☐ No
11. Would you like straighter teeth? .... ☐ Yes ☐ No
12. Have you had your teeth straightened/worn braces? .... ☐ Yes ☐ No
13. Are you concerned with bad breath (malodor)? .... ☐ Yes ☐ No
14. Are you concerned with snoring or sleep apnea? .... ☐ Yes ☐ No
15. Are you concerned with grinding or clenching your teeth (bruxism)? .... ☐ Yes ☐ No
16. Do you wear a bite guard? .... ☐ Yes ☐ No
17. Are you aware of possible TMJ problems - does your jaw joint make noise, lock up or create pain? ...... ☐ Yes ☐ No
18. Are you interested in sleep/sedation dentistry? .... ☐ Yes ☐ No
19. Is there anything else that would be valuable for your dentist to know to best care for you? ______________

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- **I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.**
- **I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.**
- **I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.**

Patient Signature________________________________ Date ______________

(Parent/Guardian)

Dentist Signature________________________________ Date ______________