



**ADULT MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

Primary reason for this dental appointment [ ] Examination [ ] Emergency [ ] Consultation

**DENTAL HISTORY**

Do you have a specific dental problem? Describe \_\_\_\_\_ [ ] Yes [ ] No

Do you like your smile? Why? \_\_\_\_\_ [ ] Yes [ ] No

Does food catch between your teeth? Any loose 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? Do you brux or grind? \_\_\_\_\_ [ ] Yes [ ] No

Have your past experiences in a dental office always been positive? \_\_\_\_\_ [ ] Yes [ ] No

Do you have dental examinations on a routine basis? Last Visit \_\_\_\_\_ [ ] Yes [ ] No

Name of previous dentist (optional) \_\_\_\_\_

Date of last full mouth x-rays (16 small films or panoramic) \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Have you been under the care of a physician in the past two years? \_\_\_\_\_ [ ] Yes [ ] No  
Why? \_\_\_\_\_

Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ [ ] Yes [ ] No

Are you taking any medications, pills or drugs? What? \_\_\_\_\_ [ ] Yes [ ] No

Medication \_\_\_\_\_ Reason \_\_\_\_\_

Medication \_\_\_\_\_ Reason \_\_\_\_\_

Medication \_\_\_\_\_ Reason \_\_\_\_\_

Medication \_\_\_\_\_ Reason \_\_\_\_\_

Do you use tobacco products of any kind? \_\_\_\_\_ [ ] Yes [ ] No

Are you allergic to any medications or substances? Please check box below [ ] Yes [ ] No  
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Other \_\_\_\_\_

Women (please mark)  Pregnant  Nursing  Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check appropriate boxes.  
 If yes to any of the starred conditions, please call prior to your appointment... pre-medication may be required.

	Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lung Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
* Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	(TB , asthma , emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Chemical/Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Dependency	<input type="checkbox"/>	<input type="checkbox"/>
* Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
* Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
* Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily/Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problem	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
			Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>

Do you have another, disease, condition or problem not listed?  Yes  No

Have you ever had any other serious illness not checked above? Discuss  Yes  No

Do you wish to talk to the dentist privately about any problem?  Yes  No

To the best of my knowledge, all preceding answers are correct. If I have any changes in my health status or medications, I shall inform the dentist and staff prior to or at my next dental appointment without failure.

Date

PATIENT NAME (PARENT/GUARDIAN) \_\_\_\_\_

Signature: \_\_\_\_\_

Reviewed By Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

History Review and Significant Findings

**MEDICAL UPDATES**

Date \_\_\_\_\_ Changes \_\_\_\_\_ Patient's Signature \_\_\_\_\_ BP \_\_\_\_\_ Reviewed By Dr. \_\_\_\_\_

New Meds: \_\_\_\_\_

Date \_\_\_\_\_ Changes \_\_\_\_\_ Patient's Signature \_\_\_\_\_ BP \_\_\_\_\_ Reviewed By Dr. \_\_\_\_\_

New Meds: \_\_\_\_\_

Date \_\_\_\_\_ Changes \_\_\_\_\_ Patient's Signature \_\_\_\_\_ BP \_\_\_\_\_ Reviewed By Dr. \_\_\_\_\_

New Meds: \_\_\_\_\_