COHIL FAMILY DENTISTRY
FAMILY, COSMETIC, AND RESTORATIVE DENTISTRY

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	[ ] [N]	Lung Trouble (TB , asthma , emphysema)	[ ] [N]	Artificial Joint	[ ] [N]
* Heart Murmur	[ ] [N]	Breathing Problem	[ ] [N]	Venereal Disease	[ ] [N]
Irregular Heart Beat	[ ] [N]	Hay Fever	[ ] [N]	HIV Positive/AIDS	[ ] [N]
Angina/Chest Pain	[ ] [N]	Sinus Trouble	[ ] [N]	Chemical/Alcohol Dependency	[ ] [N]
Heart Attack/Failure	[ ] [N]	Cancer	[ ] [N]	Cold Sores	[ ] [N]
* Congenital Heart Disorder	[ ] [N]	Radiation Treatment	[ ] [N]	Herpes	[ ] [N]
* Mitral Valve Prolapse	[ ] [N]	Chemotherapy	[ ] [N]	Stroke	[ ] [N]
Scarlet Fever	[ ] [N]	Stomach/Intestinal Disease	[ ] [N]	Convulsions	[ ] [N]
Rheumatic Fever	[ ] [N]	Diabetes	[ ] [N]	Epilepsy or Seizures	[ ] [N]
* Artificial Heart Valve	[ ] [N]	Liver Disease/Hepatitis	[ ] [N]	Fainting or Dizziness	[ ] [N]
Heart Pace Maker	[ ] [N]	Kidney Problems	[ ] [N]	Glaucoma	[ ] [N]
High Blood Pressure	[ ] [N]	Renal Dialysis	[ ] [N]	Tumors or Growths	[ ] [N]
Blood Disease	[ ] [N]	Thyroid Disease	[ ] [N]	Nervousness	[ ] [N]
Bruise Easily/Anemia	[ ] [N]	Arthritis/Gout	[ ] [N]	Psychiatric Care	[ ] [N]
Bleeding Problem	[ ] [N]	Frequent Headaches	[ ] [N]	Alzheimer's Disease	[ ] [N]

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: _____