Adult Medical History

First Name: _____ Last Name: _____DOB: ____/____/____

What is the reason for seeking dental care? ❑ Checkup/cleaning for routine care ❑ Dental care for a specific problem
Explain: _____

Name of previous dentist: _____ Date of last dental visit: _____

Are you under the care of a physician now? ❑ Yes ❑ No

Do you have any of the following?
(Please check/circle any that apply)

❑ Abnormal/prolonged bleeding following injuries
❑ ADD / ADHD (circle)
❑ AIDS / HIV positive (circle)
❑ Alcoholism or other addiction: _____
❑ Anemia or blood disorders
❑ Anxiety, emotional condition, nervous breakdowns (circle):
_____
❑ Arthritis
❑ Artificial joint, date & type: _____
❑ Artificial valve
❑ Asthma, breathing problems shortness of breath (circle)
❑ Autism/ Autism Spectrum (circle)
❑ Blood disorder
❑ Cancer or tumor, explain:
_____

❑ Cold Sores
❑ High Cholesterol
❑ Diabetes = **Type I or II** _____
❑ Epilepsy, seizures, or fainting spells (circle)
❑ Hay fever or sinus trouble (circle)
❑ Headaches, back aches, neck aches (circle)
❑ Heart attack; Date: _____
❑ Heart ailment or angina (circle)
❑ Heart murmur, mitral valve prolapse, heart defect (circle)
❑ Hepatitis A, B, C (circle)
❑ Herpes or cold sores (circle)
❑ High or low blood pressure (circle)
❑ Hospitalizations in the last 5 years, reason:
_____

❑ Liver disease (jaundice, cirrhosis or other)
❑ Kidney disease
❑ Migraine headaches or frequent headaches (circle)
❑ Neurologic condition
❑ Pacemaker
❑ Radiation or chemo treatment
❑ Rheumatic fever or rheumatic heart disease
❑ Seasonal Allergies
❑ Stroke, date: _____
❑ Thyroid Condition
❑ Tuberculosis or other lung problems
❑ Venereal disease; Herpes, Gonorrhea, Syphilis (circle)

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Do you have any limitations on diet or activity? _____
_____

Women: ❑ Taking hormones or contraceptives
❑ Pregnant; due date: _____

Are you allergic to, or have you reacted adversely to any of the following?

❑ Latex ❑ Sulfa drugs
❑ Other Antibiotic ❑ Aspirin
❑ Codeine, Vicodin or another narcotic (circle)
❑ Barbiturates, sedatives or sleeping pills (circle)
❑ Penicillin/ Amoxicillin
❑ Other: _____
_____

Do you have any of the following?

❑ Pain in teeth ❑ Pain in gums
❑ Pain in jaw ❑ Pain in head/neck
❑ Sores on lips/mouth ❑ Loose teeth
❑ Bad breath ❑ Dentures/ Partials
❑ Snore ❑ Grind/clench teeth
❑ Sleep apnea ❑ Food getting stuck between teeth
❑Bleeding gums when brushing or flossing

Have you ever had any of the following?

❑ Tooth extraction ❑ Oral surgery
❑ Periodontal (gum) surgery ❑ Deep Cleaning/Scaling
❑ Injury to jaw/teeth

Are you taking any medications, vitamin or supplements?
Please list ALL medications/supplements you are taking;

_____
_____
_____
_____
_____
_____

Do you have any other condition, disease or problem not listed above?

_____
_____

_____
Patient/Guardian Signature

_____
Date