# *Adult Medical History*

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*general dentistry*

**PATIENT FULL NAME**_____ **DATE OF BIRTH**_____

**NAME OF MEDICAL PHYSICIAN**_____ **LAST EXAM**_____

**DO YOU HAVE OR HAVE EVER HAD?**

| | | | |
|---|---|---|---|
| ☐ Abnormal Bleeding | ☐ Emphysema | ☐ Jaundice | ☐ Respiratory Problems |
| ☐ AIDS or HIV | ☐ Epilepsy/Convulsions | ☐ Jaw Pain | ☐ Seizures |
| ☐ Anemia | ☐ Fainting/Dizziness | ☐ Kidney Disease | ☐ Sexually Transmitted Diseases |
| ☐ Angina | ☐ Glaucoma | ☐ Leukemia | ☐ Stomach Trouble/Ulcer |
| ☐ Arthritis | ☐ Hay Fever/Allergies | ☐ Liver Disease | ☐ Stroke |
| ☐ Artificial/Damaged Heart Valves | ☐ Heart Attack | ☐ Low Blood Pressure | ☐ Swollen Ankles |
| ☐ Asthma | ☐ Heart Disease | ☐ Mitral Valve Prolapse | ☐ Thyroid Problems |
| ☐ Cancer | ☐ Heart Murmur | ☐ Osteoporosis | ☐ Tuberculosis |
| ☐ Cardiac Pacemaker | ☐ Heart Trouble | ☐ Radiation Therapy | OTHER:_____ |
| ☐ Chest Pains | ☐ Hemophilia | ☐ Rheumatic Fever | _____ |
| ☐ Diabetes | ☐ Hepatitis A B C | ☐ Rheumatism | _____ |
| ☐ Easily Winded | ☐ High Blood Pressure | ☐ Recent Weight Loss | _____ |

**ARE YOU UNDER MEDICAL TREATMENT NOW?**.....Y N EXPLAIN_____

**MEDICATIONS**……..…….....Y N

PLEASE LIST _____

**HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESSES WITHIN THE LAST 5 YEARS?**

EXPLAIN_____

**HAVE YOU HAD A JOINT REPLACEMENT OR IMPLANT?**.....Y N

IF SO, WHEN?_____

**DO YOU USE ALCOHOL?**.....Y N

**DO YOU USE TOBACCO PRODUCTS?**.....Y N

**DO YOU USE CONTROLLED SUBSTANCES?**.....Y N

**ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?**

ANTIBIOTICS……..Y N

PLEASE LIST_____

ASPIRIN……..……...Y N

IODINE……..……Y N

LATEX/RUBBER……..……Y N

LOCAL ANESTHETIC (I.E. NOVOCAINE)……..……...……Y N

PLEASE LIST_____

SEDATIVES……..……..…..Y N

SULFA DRUGS……..……..Y N

OTHER ALLERGIES PLEASE LIST _____

**WOMEN ONLY:**

ARE YOU PREGNANT OR THINK YOU MAY BE…….Y N

ARE YOU TAKING ORAL CONTRACEPTIVES……Y N

ARE YOU NURSING……..…..…….…..Y N

**AUTHORIZATION AND RELEASE**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and /or health practitioners. I agree to notify the office of any health changes that may occur during the year.

_____ _____

***SIGNATURE*** ***DATE***

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