

## Adult Medical History

<b>Patient Name:</b>	<b>Preferred Name:</b>
<b>Age:</b>	<b>Name of Physician and their specialty:</b>
<b>Phone Number:</b>	<b>Most Recent examination:</b>
<b>Purpose:</b>	
<b>What is your estimate of your general health?</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	

### Medical History

<b>Have you ever had an allergic reaction to:</b>			
<b>Aspirin, ibuprofen, acetaminophen</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Erythromycin</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Codeine</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Fluoride</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Latex</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<b>Penicillin</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Tetracycline</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Local anesthetic</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Metals (Gold, Nickel)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Other</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Do you have or have you ever had?</b>			
<b>Hospitalization for illness or injury</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Heart Murmur</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>High Blood Pressure</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Stroke</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Anemia or Blood Disorder</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Tuberculosis</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Breathing or Sleep Problems (i.e. Snoring, Sinus)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Hormone Deficiency</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Digestive Disorders (i.e. gastric reflux)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Osteoporosis/osteopenia (i.e. taking bisphosphonates)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Glaucoma</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Epilepsy, Convulsions (seizures)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Viral Infections and Cold Sores</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Hepatitis</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Tumor, Abnormal Growth</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Chemotherapy</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Psychiatric Treatment</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Alcohol / Drug Dependency</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<b>Heart Problems</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Rheumatic Fever</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Low Blood Pressure</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Artificial Prosthesis (i.e. Heart Valve or Joints)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Prolonged Bleeding Due To Slight Cut</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Asthma</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Thyroid or Parathyroid Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Diabetes</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Shingles</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Arthritis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Contact Lenses</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Neurologic Problems</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Any lumps or swelling in the mouth</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>HIV / AIDS</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Radiation Therapy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Emotional Problems</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Antidepressant Medication</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Alzheimer's Disease / Dementia</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If you have been hospitalized, please specify:</b>			

<b>Are you:</b>			
<b>Presently being treated for any other illness</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Aware of any change in your general health</b>
<b>Taking medication for weight management (i.e. fen-phen)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Taking dietary supplement</b>
<b>Often exhausted or fatigued</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Subject to frequent headaches</b>
<b>A Smoker or smoked previously</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Taking recreational drugs</b>
<b>FEMALE - Taking birth control pills</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>FEMALE - Pregnant</b>
<b>MALE - Prostate disorders</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.**

**List all medications, supplements, and or vitamins taken within the last two years**

<b>Drug</b>	<b>Purpose</b>	<b>Drug</b>	<b>Purpose</b>

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

**Patient Signature:**

**Date:**

**Doctor's Signature:**

**Date:**