

ADULT MEDICAL-DENTAL HISTORY

Medical Doctor: _____ Medical Doctor Phone: _____

Have you been under the care of a Physician in the last 2 years? YES _____ NO _____

If yes please

explain: _____

Current Medications (please attach list if you have one):

Have you been hospitalized or had any surgeries in the last 5 years? YES _____ NO _____

If yes please

explain: _____

Have you had any adverse reaction to any medications or local anesthetic? YES _____ NO _____

If yes please

explain: _____

Are you allergic to or had a bad reaction to Latex or Metals? YES _____ NO _____

If yes please explain: _____

Have you taken bone sparing drugs such as Fosamax, Actonel, Boniva, or Zometa? YES _____ NO _____

If yes, how long? _____

Do you smoke? YES _____ NO _____ If yes, Packs per day? _____ # of years? _____

Do you use alcohol? YES _____ NO _____ How often? _____

(Women) Are you or could you be pregnant? YES _____ NO _____ Due date? _____

Please circle YES or NO to indicate if you have had any of the following:

| | | | |
|------------------------------|----------|---------------------------|----------|
| Heart Attack | yes / no | Asthma | yes / no |
| Heart Surgery | yes / no | Tuberculosis | yes / no |
| Chest Pains | yes / no | Hepatitis A,B, or C | yes / no |
| Congenital Heart Disease | yes / no | Blood Thinners | yes / no |
| Heart Murmur | yes / no | HIV Positive | yes / no |
| High/Low Blood Pressure | yes / no | AIDS | yes / no |
| Artificial Pins/Joints/Valve | yes / no | Psychiatric Care | yes / no |
| Rheumatic Fever | yes / no | Mitral Valve Prolapse | yes / no |
| Stroke | yes / no | Neurological Disorders | yes / no |
| Ulcers or Stomach Trouble | yes / no | Epilepsy or Seizures | yes / no |
| Diabetes | yes / no | Fainting or Dizzy Spells | yes / no |
| Radiation or Chemo Therapy | yes / no | Shortness of Breath | yes / no |
| Anemia | yes / no | Kidney Disease | yes / no |
| Hearing Problem | yes / no | Glaucoma | yes / no |
| Sinus Trouble | yes / no | Cancer/Tumors | yes / no |
| Arthritis | yes / no | Blood Transfusion | yes / no |
| | | Alcohol or Drug Addiction | yes / no |

ADULT MEDICAL-DENTAL HISTORY

Previous Dentist Name: _____ Phone: _____

Address _____

Purpose of initial visit: _____

Are you aware of any problems? _____

Date of last dental visit? _____

How often do you brush? _____

Were x-rays taken? Yes ____ No ____

Do your gums bleed or hurt? Yes ____ No ____

When was your last teeth cleaning ? _____

How often do you floss? _____

History of gum surgery? Yes ____ No ____

If yes, when? _____

Removed or lost any teeth? Yes ____ No ____

If yes, why? _____

Have you experienced any complications with previous dental treatment? Yes ____ No ____

If yes, please

explain: _____

Do you have any questions or concerns to talk to your doctor about? Yes ____ No ____

If yes, Please

explain: _____

Please circle YES or NO to any of the following that apply to you?

Do you clench or grind your teeth? yes / no

Do you have soreness or pain in your jaw? yes / no

Does food get caught in your teeth? yes / no

Do you have sensitive teeth? yes / no

Does your jaw lock or pop? yes / no

Do you have frequent headaches? yes / no

Are you happy with the appearance of your smile? yes / no

Have you had any orthodontic work? yes / no

I have completed this medical-dental history form, and by signing below I attest to the accuracy of the information provided,

Patient Signature:

X _____

Date: _____