# Adult- Medical/Dental History

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| | | | |
|---|---|---|---|
| 1. Are you under a physician's care now? If yes, please list the name and clinic phone number. | YES | NO | If Yes_____ |
| 2. Have you ever been hospitalized or had a major operation? If yes, please explain. | YES | NO | If Yes_____ |
| 3. Are you taking any medications, pills, or drugs? If yes, please list to the right. | YES | NO | If Yes_____ |
| 4. Do you require antibiotic premedication before Dental treatment? If yes, what type? | YES | NO | If Yes_____ |
| 5. Do you take blood thinners? If yes, please list. | YES | NO | If Yes_____ |
| 6. Do you use tobacco? If yes, what type? | YES | NO | If Yes_____ |

Women: Are you... (please circle that apply)

Pregnant? Nursing? Taking Oral Contraceptives? How many months pregnant?_____

Are you ALLERGIC to any of the following? (please circle that apply)

Aspirin Penicillin Codeine Acrylic Metal Latex Gloves

Sulfa Drugs Local Anesthetics Other known allergies not listed above?_____

Do you use controlled substances? YES NO

Do you have, or have had any of the following? (please circle that apply)

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV Postitive | YES | NO | Alzheimer's Disease | YES | NO |
| Anaphylaxis | YES | NO | Artificial Heart Valve | YES | NO |
| Artificial Joint | YES | NO | Asthma | YES | NO |
| Breathing Problems | YES | NO | Cancer | YES | NO |
| Cold Sores/Fever Blisters | YES | NO | Chest Pains | YES | NO |
| Diabetes | YES | NO | Drug Addiction | YES | NO |
| Epilepsy or Seizures | YES | NO | Excessive Bleeding | YES | NO |
| Excessive Thirst | YES | NO | Frequent Headaches | YES | NO |
| Heart Attack/Failure | YES | NO | Heart Murmur | YES | NO |
| Heart Trouble/Disease | YES | NO | Hepatitis B or C | YES | NO |
| High Blood Pressure | YES | NO | Kidney Problems | YES | NO |
| Leukemia | YES | NO | Liver Disease | YES | NO |
| Lung Disease | YES | NO | Mitral Valve Prolapse | YES | NO |
| Pain in Jaw Joints | YES | NO | Psychiatric Care | YES | NO |
| Sinus Trouble | YES | NO | Stomach/Intestinal Disease | YES | NO |
| Stroke | YES | NO | Tumors or Growths | YES | NO |

Have you ever had any serious illness not listed above? If yes, please explain_____

Do you have any particular dental concerns? If yes please explain_____

To the best of my knowledge, the questions have been accurately answered. I understand providing incorrect information can be dangerous to my health. It is my responsibility to inform of any changes.

**Signature of Patient, parent, or guardian:**_____ **Date:**_____