

Adult medical history form:

Please fill out and sign at the bottom.

Name _____

email address _____

Preferred _____ DOB ___/___/___ M / F

When was your last dental visit? _____

SS# _____ - _____ - _____ Occupation _____

Why have you come to the dentist today? _____

Home Address _____

How often do you brush? _____ floss? _____

Hm Ph(____) _____ Wk Ph(____) _____

Rate your current dental health _____

Employer _____

Physician _____ ph(____) _____

Spouse _____

Rate your current medical health _____

Preferred _____ DOB ___/___/___ M / F

List any Allergies _____

SS# _____ - _____ - _____ Occupation _____

Employer _____

Current Medications _____

Referred by _____

Have you ever had any of the following:

- | | | |
|------------------------------------|---------------------------------|--------------------------------------|
| Y / N – Abnormal Bleeding | Y / N – Hay Fever | Y / N – Radiation Treatment |
| Y / N – Alcohol / Drug Abuse | Y / N – Heart Attack | Y / N – Rheumatic / Scarlet Fever |
| Y / N – Anemia | Y / N – Heart Murmur | Y / N – Seizures |
| Y / N – Arthritis | Y / N – Heart Surgery | Y / N – Shingles |
| Y / N – Artificial Joints / Valves | Y / N – Hemophilia | Y / N – Sickle Cell Disease / Traits |
| Y / N – Asthma | Y / N – Hepatitis | Y / N – Sinus Trouble |
| Y / N – Blood Transfusion | Y / N – Herpes / Fever Blisters | Y / N – Stroke |
| Y / N – Cancer / Chemotherapy | Y / N – High Blood Pressure | Y / N – Thyroid Problems |
| Y / N – Colitis | Y / N – HIV+ / AIDS | Y / N – Tuberculosis |
| Y / N – Congenital Heart Defect | Y / N – Hospitalized | Y / N – Ulcers |
| Y / N – Diabetes | Y / N – Kidney Problems | Y / N – Venereal Disease |
| Y / N – Difficult Breathing | Y / N – Liver Disease | Other _____ |
| Y / N – Emphysema | Y / N – Low Blood Pressure | _____ |
| Y / N – Fainting Spells | Y / N – Mitral Valve Prolapse | _____ |
| Y / N – Frequent Headaches | Y / N – Pacemaker | _____ |
| Y / N - Glaucoma | Y / N – Psychiatric Problems | _____ |

Have you ever taken -- Actonel; Boniva; Fosamax; Fosamax Plus D; Skelid; or Didronel please circle any you have taken

Drug Allergies? Please circle or list: _____
.....Penicillin.....Erythromycin.....Tetracycline.....Codeine.....Aspirin.....Sulfa drugs.....

For Women: Are you taking birth control medication? Y / N Are you pregnant? Y / N ...in _____ month

This information is true to the best of my knowledge. Signed _____ date _____

Emergency contact person _____ ph _____ relationship _____