Adult Medical History

Patient name: _____ Date of birth:_____
Name of your medical doctor: _____
Phone # of your medical doctor: _____
Date of last visit to medical doctor: _____
Name of previous dentist: _____
Date of last visit to dentist: _____

Dental Health History

Please mark any that apply:	**Yes**	**No**
Are you apprehensive about dental treatment?	□	□
Have you had problems with previous dental treatment?	□	□
Do you gag easily?	□	□
Do you wear dentures?	□	□
Does food catch between your teeth?	□	□
Do you have difficulty in chewing your food?	□	□
Do you chew on only one side of your mouth?	□	□
Do you avoid brushing any part of your mouth because of pain?	□	□
Do your gums bleed easily?	□	□
Do your gums bleed when you floss?	□	□
Do your gums feel tender or swollen?	□	□
Have you ever noticed slow healing sores in or about your mouth?	□	□
Are your teeth sensitive?	□	□
Do you feel twinges of pain when your teeth come in contact with:		
Hot food or liquids?	□	□
Cold foods or liquids?	□	□
Sours?	□	□
Sweets?	□	□
Do you take fluoride supplements?	□	□
Are you dissatisfied with the appearance of your teeth?	□	□
Do you prefer to save your teeth?	□	□
Do you want complete dental care?	□	□

Dental Health History Continued

	Yes	No
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise that bothers you or others?	□	□
Do you clench or grind your jaws frequently?	□	□
Do your jaws ever feel tired?	□	□
Does your jaw get stuck so that you can't open freely?	□	□
Does it hurt when you chew or open wide to take a bite?	□	□
Do you have earaches or pain in front of the ears?	□	□
Do you have any jaw symptoms or headaches upon awaking in the morning?	□	□
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	□	□
Do you find jaw pain or discomfort extremely frustrating or depressing?	□	□
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	□	□
Do you have a temporonmandibular (jaw) disorder (TMD, TMJ)?	□	□
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	□	□
Are you unable to open your mouth as far as you want?	□	□
Are you aware of an uncomfortable bite?	□	□
Have you had a blow to the jaw (trauma)?	□	□
Are you a habitual gum chewer or pipe smoker?	□	□

Medical Health History

Do you have, or have you had any of the following? Please mark any that apply.

Heart Problems	Yes	No
Chest Pain		
Shortness of breath	□	□
Blood pressure problem	□	□
Heart murmur	□	□
Heart valve problem	□	□
Taking heart medication	□	□
Rheumatic fever	□	□
Pacemaker	□	□
Artificial heart valve	□	□
Blood Problems		
Easy bruising	□	□
Frequent nosebleeds	□	□
Abnormal bleeding	□	□
Blood disease (anemia)	□	□
Ever require a blood transfusion?	□	□
Allergy Problems		
Hay fever	□	□
Sinus problems	□	□
Skin rashes	□	□
Taking allergy medication	□	□
Asthma	□	□
Intestinal Problems		
Ulcers	□	□
Weight gain or loss	□	□
Special diet	□	□
Constipation/ Diarrhea	□	□
Kidney or bladder problems	□	□
Bone or Joint Problems		
Arthritis	□	□
Back or neck pain	□	□
Joint replacement- (e.g., total hip, pins, implants)	□	□
Fainting spells, Seizures, or Epilepsy	□	□
Frequent or severe headaches	□	□
Thyroid problems	□	□
Persistent cough or swollen glands	□	□
Premedication required by physician	□	□
Cancer/ Tumor	□	□

Are you allergic or have you reacted adversely to any of the following?:

Local anesthetics ("Novocaine")	□	□
Penicillin or other antibiotics	□	□
Sulfa drugs	□	□
Barbiturates, sedatives, or sleeping pills	□	□
Aspirin, Acetaminophen, or Ibuprofen	□	□
Codeine, Demerol, or other narcotics	□	□
Reaction to metals	□	□
Latex or rubber dam	□	□
Other	□	□

Dentist initial: _____ Date: _____

Patient Signature: _____

Diabetes	Yes	No
Urinate more than 6 times	□	□
Thirsty or mouth is dry much of the time	□	□
Family history of diabetes	□	□
Tuberculosis or other respiratory disease	□	□
Do you drink alcohol?	□	□
If yes, how much?	_____	
Do you smoke?	□	□
If yes, how much?	_____	
Hepatitis, jaundice, or liver trouble	□	□
Herpes or other STD	□	□
HIV-positive/ AIDS	□	□
Glaucoma	□	□
Do you wear contact lenses?	□	□
History of head injury?	□	□
Epilepsy or other neurological disease?	□	□
History of alcohol or drug abuse?	□	□

Do you have any disease, condition or problem not listed previously that you feel we should know about?

If so, please describe _____

_____

During the past 12 months, have you taken any of the following?

Antibiotics or sulfa drugs	□	□
Anticoagulants (e.g., Coumadin)	□	□
High Blood pressure medication	□	□
Tranquilizers	□	□
Insulin, Orinase, or similar drug	□	□
Aspirin	□	□
Digitalis or drugs for heart trouble	□	□
Nitroglycerin	□	□
Cortisone (steroids)	□	□
Natural remedies	□	□
Nonprescription drugs/supplements	□	□

Please list any medications you might be taking:

_____

_____

Women		
Are you taking contraceptives or other hormones?	□	□
Are you pregnant?	□	□
If so, expected delivery date:	_____	
Are you nursing?	□	□
Have you reached menopause?	□	□

If so, do you have any symptoms? _____