Patient Name: _____ Date: _____

ADULT MEDICAL HISTORY

Certain illnesses and drugs may make it necessary to alter our treatment. In an effort to render the best possible oral health care to you and/or your child. It is necessary to have the following information. **HAVE YOU EVER HAD OR HAVE:**

Y	N		Y	N		Y	N		ALLERGIC TO: Y	N
☐	☐	Anemia/Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐ Aspirin
☐	☐	Arthritis	☐	☐	Heart Trouble	☐	☐	Neck/Head Pain	☐	☐ Codeine
☐	☐	Asthma/Hay Fever	☐	☐	Open Heart Surgery	☐	☐	Pregnant	☐	☐ Local Anesthesia
☐	☐	Blood Pressure/High	☐	☐	Pace Maker	☐	☐	Rheu Fever/Murmur	☐	☐ Penicillin
☐	☐	Blood Pressure/Low	☐	☐	Hepatitis/Jaundice	☐	☐	Stroke	☐	☐ Sedative/Tranq.
☐	☐	Cancer/Tx/X-Ray	☐	☐	Herpes Virus	☐	☐	TB/Lung Disease	☐	☐ Premedicate
☐	☐	Diabetes	☐	☐	HIV Positive/AIDS	☐	☐	TMJ/Clicking Joint	☐	☐ Medical Alert
☐	☐	Epilepsy/Seizures	☐	☐	Ulcers or Stomach Disorder	☐	☐	Bleeding or Clotting Prob.	☐	☐ Latex
☐	☐	Fainting/Nervous	☐	☐	Joint Replacement	☐	☐	Veneral Disease	☐	☐ _____
☐	☐	Migraine Headaches	☐	☐	Other Illness _____					

☐ ☐ Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, arterioscelerosis)
☐ ☐ Do any wounds heal slowly or present complications?
☐ ☐ Are you presently taking any medicine? Specify: _____
☐ ☐ Are you presently under the care of a physician?
☐ ☐ When was your last physical exam? _____
☐ ☐ Have you had X-ray treatments or chemotherapy?
☐ ☐ Are you presently on a diet?
☐ ☐ Have you ever been hospitalized? Date: _____ Reason: _____
☐ ☐ Women: ( ) Are you taking birth control pills? ( ) Are you pregnant?

DENTAL HISTORY

Date of Last Dental Exam: _____
Date of Last Full Mouth X-Ray: _____ Where Taken: _____

If you answer "yes" to any of the following questions, please explain.

Y	N	
☐	☐	Have you had trouble from previous dental care? _____
☐	☐	Do you have pain in your jaw or near your ears? _____
☐	☐	Do you have any unhealed injuries or inflamed areas in or around your mouth? _____
☐	☐	Have you experienced any growths or sore spots in your mouth? _____
☐	☐	Does any part of your mouth hurt when clenched? _____
☐	☐	Have you ever had Novocaine or other local anesthetic? _____
☐	☐	Have you ever had Nitrous Oxide (laughing gas)? _____
☐	☐	Have you ever had general anesthesia? _____
☐	☐	Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics? _____
☐	☐	Have you had any difficult extractions in the past? _____
☐	☐	Have you had prolonged bleeding following extractions in the past? _____
☐	☐	Do your gums bleed? _____
☐	☐	Do you have a bad taste in your mouth, or mouth odor? _____
☐	☐	Have you had instructions on the care of your gums? _____
☐	☐	Do you chew on only one side of your mouth? If so, why? _____
☐	☐	Do you habitually clench or grind your teeth during the night or day? _____
☐	☐	Is any part of your mouth sensitive to pressures or irritants (hot, cold, or sweets)? _____
☐	☐	Have you ever had gum treatments? _____

Is there any other problem not covered above that you would like to discuss?

_____

_____

_____ _____ _____ _____

PATIENT SIGNATURE DATE DOCTOR SIGNATURE DATE