

MEDICAL HISTORY-ADULT

Name \_\_\_\_\_

List any drug or medicine allergies \_\_\_\_\_

List drugs or medicine presently being taken \_\_\_\_\_

Do you have any restrictions to dental treatment by your physician? \_\_\_\_\_

Are you currently under a physicians care? Y N Explain \_\_\_\_\_

Does your medical history include any of the following?

- \_\_\_\_\_ High Blood Pressure      \_\_\_\_\_ Asthma, hayfever, emphysema      \_\_\_\_\_ Special diet
- \_\_\_\_\_ Low Blood Pressure      \_\_\_\_\_ Healing Complications      \_\_\_\_\_ Psychiatric care
- \_\_\_\_\_ Diabetes      \_\_\_\_\_ Sinus problems      \_\_\_\_\_ Arthritis

Are you pregnant? Y N

Does your medical history include any of the following conditions? If yes, explain

- Heart trouble \_\_\_\_\_      Surgery including heart valves, pins, joint replacement, etc. \_\_\_\_\_
- Rheumatic fever \_\_\_\_\_      Venereal disease \_\_\_\_\_
- Hepatitis \_\_\_\_\_      Stroke \_\_\_\_\_
- Ulcers \_\_\_\_\_      Anemia \_\_\_\_\_
- Malignancies \_\_\_\_\_      Tuberculosis \_\_\_\_\_
- Herpes virus \_\_\_\_\_      Epilepsy \_\_\_\_\_
- Other \_\_\_\_\_

Are you presently experiencing a dental problem? Y N Explain \_\_\_\_\_

When was your last dental appointment? \_\_\_\_\_ What was done? \_\_\_\_\_

Do you use a soft toothbrush? Y N

Please circle

- Y N Are your teeth sensitive to heat, cold, sweets, biting pressure
- Y N Does food catch between your teeth
- Y N Do your gums bleed when you brush
- Y N Have you noticed any swelling around any teeth
- Y N Do you have an unpleasant taste or odor in your mouth
- Y N Do you often clench or grind your teeth when asleep or angry
- Y N Do you have popping, clicking, or soreness of jaws
- Y N Are you dissatisfied with your teeth and their appearance
- Y N Do you smoke, use chewing tobacco, or smokeless tobacco
- Y N Have you had a reaction to local anesthetic
- Y N Have you ever had any teeth removed, If yes, when \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed:

Initial \_\_\_\_\_ Date \_\_\_\_\_      Initial \_\_\_\_\_ Date \_\_\_\_\_      Initial \_\_\_\_\_ Date \_\_\_\_\_