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Adult Medical History

Patient name _____ Birthdate _____

Primary physician _____ Phone _____

Are you currently under a doctor's care? ◯ Yes ◯ No

If yes, please describe _____

Have you been hospitalized or had any surgeries in the last 5 years? ◯ Yes ◯ No

If yes, please list treatment and/or surgery _____

Female patient: Are you pregnant? ◯ Yes ◯ No Date Due _____ Nursing? ◯ Yes ◯ No

Do you smoke? ◯ Yes ◯ No Packs per day _____

Do you use alcohol? ◯ Yes ◯ No How much? _____

Have you ever had an unfavorable reaction following dental treatment? ◯ Yes ◯ No

Describe reaction _____

Are you sensitive or allergic to:

☐ Penicillin ☐ Tetracycline ☐ Metals ☐ Sedatives ☐ Sulfa Drugs
☐ Codeine ☐ Erythromycin ☐ Latex ☐ Dental Anesthetics

Describe reaction: _____

Are you allergic to any other medications, drugs or treatments? ◯ Yes ◯ No

If yes, please explain _____

Have you taken any bone density medications or IV infusions as a medical treatment? ◯ Yes ◯ No

If yes, how long? _____ If other, please list medication _____

Are you taking any drugs or medications at this time? ◯ Yes ◯ No

List all medications you are taking _____

Adult Medical Conditions

Do you have or have you experienced any of the following? Please check all that apply.

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse History
- ☐ Alzheimer's or Dementia
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Pins, Bones or Joints
  - When? _____
  - Where? _____
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ AIDS/HIV
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Persistent Cough
- ☐ Cannibus Use
- ☐ Cancer/Tumors
  - List Type _____
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Chicken Pox
- ☐ Chronic Pain
- ☐ Cold Sores
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ C0PD
- ☐ Diabetes
  - List Type _____
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing Problem
- ☐ Heart Attack
  - Date _____
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
  - Type _____
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
  - List Type _____
- ☐ Osteoporosis
- ☐ Pacemaker
  - Date _____
  - Type _____
- ☐ Persistant Cough
- ☐ Psychiatric Treatment
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke/CVA
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcers/Acid Reflux
- ☐ Other

Please list any serious medical conditions(s) not indicated above that you have experienced in the last 5 years:

Emergency Contact _____ Phone _____ Relationship _____

By signing this form, I acknowledge that the information provided is true and accurate to the best of my knowledge.

Signer's full name _____

Signature _____ Date _____