Adult Medical and Dental History

Patient Name ______________________________ D.O.B. ____________________

Emergency Contact (Name/Phone #) ______________________________

Medical History

1. Physician______________________ Address______________________
2. When was your last physical examination? ______________________
3. Are you under the care of a physician? .... ☐Yes ☐No
   If yes, for what reason(s)? ______________________
4. Are you presently taking any medications/drugs/pills/herbals/supplements? .... ☐Yes ☐No
   If yes, please list: ______________________
5. (Women) Is there a chance you are pregnant? .... ☐Yes ☐No
   If yes, anticipated due date? ______________________
6. Do you take oral contraceptives? .... ☐Yes ☐No
7. Are you allergic/sensitive to: ☐None ☐Codeine ☐Penicillin ☐Local Anesthetic ☐Latex
   ☐Pine Nuts ☐Dyes ☐Other: ______________________
8. Do you smoke, chew tobacco, or use E-cigarettes? .... ☐Yes ☐No
   If yes, please indicate which one(s), daily frequency, and how long? ______________________
9. Do you have Diabetes? .... ☐Yes ☐No
   If yes, please indicate: ☐Type 1 ☐Type 2 Last HbA1c date and level: ______________________
10. Do you have, or have you ever had:

Condition		Condition	
Abnormal blood pressure	☐Yes ☐No	Heart pacemaker	☐Yes ☐No
Anemia	☐Yes ☐No	Heart surgery	☐Yes ☐No
Arthritis	☐Yes ☐No	Heart trouble	☐Yes ☐No
Artificial heart valve/stent/graft	☐Yes ☐No	Hepatitis (Type __)	☐Yes ☐No
Artificial joint replacements	☐Yes ☐No	HIV positive/AIDS	☐Yes ☐No
Asthma	☐Yes ☐No	Jaundice	☐Yes ☐No
Cancer	☐Yes ☐No	Kidney trouble/Dialysis	☐Yes ☐No
Chemical dependency	☐Yes ☐No	Leukemia	☐Yes ☐No
Chemotherapy/radiation	☐Yes ☐No	Oral herpetic lesions	☐Yes ☐No
Congenital heart defects	☐Yes ☐No	Osteoporosis/treatment w/Bisphosphonates	☐Yes ☐No
Corticosteroid treatment	☐Yes ☐No	Psychiatric care	☐Yes ☐No
Epilepsy/seizures	☐Yes ☐No	Rheumatic fever	☐Yes ☐No
Excessive or prolonged bleeding	☐Yes ☐No	Sexually transmitted disease	☐Yes ☐No
Fainting spells	☐Yes ☐No	Sinus trouble	☐Yes ☐No
Glaucoma	☐Yes ☐No	Stroke	☐Yes ☐No
Hearing impaired	☐Yes ☐No	Thyroid problem	☐Yes ☐No
Heart murmur	☐Yes ☐No	Tuberculosis or Lung Disease	☐Yes ☐No
		Ulcers/GERD	☐Yes ☐No

11. Do you take pre-medication for anything? .... ☐Yes ☐No
    If you pre-medicate, what for? ______________________
12. Have you had any other serious illness, hospitalization or accident? .... ☐Yes ☐No
    If yes, please explain: ______________________

(Over Please)

Adult Medical and Dental History

Dental History

1. Former Dentist ______________________________________ Address____
2. When did you last visit a dentist? ______________________ When was your last cleaning? _______________________

   X-rays taken? .... ☐Yes ☐No

   If yes, ☐Full Mouth Series ☐Bitewings ☐Panoramic

   What was done at your last visit? ____

   Why did you leave that dentist? ____

   Has any dental treatment been recommended to you that you have not had done? _____________________________
3. Are you aware of any dental problems .... ☐Yes ☐No

   If yes, please explain: ____
4. Please rate the present condition of your mouth: ***Poor*** 1 2 3 4 5 6 7 8 9 10 ***Excellent***
5. Have you ever been treated for gum disease? .... ☐Yes ☐No

   If yes, what was done? ____
6. Do you have well water? .... ☐Yes ☐No
7. Is your water fluoridated? .... ☐Yes ☐No
8. Are your teeth sensitive to: ☐Nothing ☐Sweet ☐Cold ☐Heat ☐Pressure
9. Please rate the appearance of your smile: ***Poor*** 1 2 3 4 5 6 7 8 9 10 ***Excellent***
10. Would you like a whiter smile? .... ☐Yes ☐No
11. Would you like straighter teeth?... ☐Yes ☐No
12. Have you had your teeth straightened/worn braces? .... ☐Yes ☐No
13. Are you concerned with bad breath (malodor)? .... ☐Yes ☐No
14. Are you concerned with snoring or sleep apnea? .... ☐Yes ☐No
15. Are you concerned with grinding or clenching your teeth (bruxism)? .... ☐Yes ☐No
16. Do you wear a bite guard? .... ☐Yes ☐No
17. Are you aware of possible TMJ problems? (Does your jaw joint make noise, lock up, or create pain?) .... ☐Yes ☐No
18. Are you interested in sleep/sedation dentistry? .... ☐Yes ☐No
19. Is there anything else that would be valuable for your dentist to know to best care for you? ______________________

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☐ **I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.**

☐ **I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.**

☐ **I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.**

Patient Signature ____ **Date** _________________________

(Parent/Guardian)

Dentist Signature ____ **Date** _________________________