Adult Medical History

Patient's Name: **Date:**__________

Please describe your current physical health:

☐ Good ☐ Fair ☐ Poor Name of Physician:__________________
Are you currently under the care of a physician? ☐ Yes ☐ No Physician Phone #:__________________
If no, please explain:____

Please list all prescription/over the counter drugs that you are currently taking:

1. Medication: ____________ Taken for:____________ 3. Medication: ___________ Taken for:_________________
2. Medication: ____________ Taken for:____________ 4. Medication: __________ Taken for:_________________

Are you currently or have you ever taken a drug containing Bisphosphonates in either tablet or IV form (ie Fosomax, Didronel)? ☐ Yes ☐ No If yes, how long? ____

For Women:

Are you taking birth control Pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #'s:_________
Are you nursing? ☐ Yes ☐ No

Do you have any of the following medical conditions which require pre-medication? (Please circle)

Y N	Artificial Heart Valve	**Y N**	Congenital Heart Disease/Defect (CHD)
Y N	Heart Transplant	**Y N**	History of Infective Endocarditis

Do you need pre-medication for dental procedures? ☐ Yes ☐ No If yes, please explain:__________________
____

Have you ever had any of the following medical conditions? (Please circle)

Y N	Abnormal Bleeding	**Y N**	Hepatitis
Y N	Arthritis	**Y N**	High/Low Blood Pressure
Y N	Artificial Bones/Joints/Valves	**Y N**	HIV+/AIDS
Y N	Asthma/Difficulty Breathing	**Y N**	Hospitalized for Any Reason
Y N	Blood Transfusion	**Y N**	Mental Health Problem
Y N	Cancer/Chemotherapy	**Y N**	Osteoporosis/Osteopenia
Y N	Diabetes	**Y N**	Rheumatic/Scarlet Fever
Y N	Drug/Alcohol Abuse	**Y N**	Shingles Sickle Cell Disease/Traits
Y N	Emphysema Epilepsy/Seizure/Convulsions	**Y N**	Sinus Problems
Y N	Fever Blisters/Herpes	**Y N**	Skin Disorder
Y N	Frequent Headaches/Migraines	**Y N**	Ulcers/Colitis
Y N	Glaucoma	**Y N**	Vision, Hearing, Speech Difficulties
Y N	Handicaps/Disabilities	**Y N**	Other (Describe below)
Y N	Hemophilia		

Please list any medical conditions that you have had:____
____

Are you allergic to any of the following? (Please circle)

Y N	Acetaminophen (Tylenol)	**Y N**	Dental Anesthetics	**Y N**	Metals (Nickel)
Y N	Aspirin	**Y N**	Ibuprofen (Advil, Motrin)		
Y N	Acrylic/Plastics	**Y N**	Latex		

Please list any other drugs/materials that you are allergic to:____
____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature:____________________________ **Date**:____________

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