## ADULT MEDICAL HEALTH HISTORY

Name: ______________________________________________ Today's Date: _____________________________

Birthdate: _____________________ Age: _______

Date of last health care exam: ________________What was this exam for?_________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:___________________________________________________________________________

Are you currently receiving care? No Yes If yes, nature of care: _________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____________________________________________________________________
2. ____________________________________________________________________
3. ____________________________________________________________________
4. ____________________________________________________________________

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

| Condition | No | Yes | Condition | No | Yes |
|---|---|---|---|---|---|
| Anemia or Blood Disorder | No | Yes | Hepatitis (any form) | No | Yes |
| Arthritis, Rheumatism, or other inflammatory disease | No | Yes | High Blood Pressure | No | Yes |
| Asthma | No | Yes | Joint Replacement, when placed? | No | Yes |
| Abnormal bleeding from a cut | No | Yes | Kidney Disease | No | Yes |
| Cancer or Tumor | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Diabetes | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Emphysema, COPD, or Respiratory/Lung Illnesses | No | Yes | Psychosis | No | Yes |
| Epilepsy | No | Yes | Radiation or Chemotherapy Treatment, when? | No | Yes |
| Fainting or Dizzy Spells | No | Yes | Rheumatic Fever | No | Yes |
| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | H.I.V. Infection/AIDS or ARC | No | Yes |
| Congenital Heart Disease | No | Yes | Venereal Disease | No | Yes |
| Heart Disease, Heart Attack, Heart Surgery | No | Yes | Other Conditions | No | Yes |
| Heart Stent, when placed? | No | Yes | Recurrent Illnesses | No | Yes |

| Question | No | Yes |
|---|---|---|
| Do you require antibiotics prior to dental treatment?<br>For what condition? | No | Yes |

List any other conditions:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Are you taking any of these medications?

| | | | | | |
|---|---|---|---|---|---|
| Warfarin, Coumadin, or Plavix | No | Yes | Tagamet (cimetidine) or Prilosec (omeprazole) | No | Yes |
| Antacids | No | Yes | Cardizem (diltiazem) or Calan, Isoptin(Verapamil)? | No | Yes |
| Dilantin or Tegretol | No | Yes | Serzone (nefazodone) | No | Yes |
| Barbiturates (any) | No | Yes | Diflucan (fluconazole) or Sporonox (itraconazole) | No | Yes |
| St. John's Wort or Kava-Kava | No | Yes | Biaxin (clarithromycin) | No | Yes |

| | | |
|---|---|---|
| Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)?<br>If so, when did the treatment begin? When did the treatment end? | No | Yes |
| Have you ever taken any prescription drugs such as fen-phen for weight loss? | No | Yes |
| Do you take prescription narcotics such as Vicodin, Lortab (hydrocodone), Percocet(oxycodone), oxycontin, Tylenol with Codeine, morphine, or methadone | No | Yes |
| Do you take Non-Steroidal Anti-inflammatory drugs (NSAIDs) such as Aspirin, Motrin (ibuprofen), Aleve (naproxen), or Celebrex (celecoxib) | No | Yes |

Please list all prescription and over the counter medications you are currently taking, including dosages:

| Medication | Dose | Medication | Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please list any dietary or herbal supplements you are taking, and for what purpose:

| Supplement | Purpose | Supplement | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Women

| | | |
|---|---|---|
| Is there any chance you could be pregnant today? | No | Yes |
| If no, are you planning a pregnancy in the near future? | No | Yes |
| Are you a nursing mother? | No | Yes |
| Are you taking birth control pills (to include Murena, contraceptive implants, or injections (Depo-prova)? | No | Yes |

Are you allergic or have you had a reaction to:

| | | | Type of reaction |
|---|---|---|---|
| Dental anesthetics | No | Yes | |
| Penicillin | No | Yes | |
| Other antibiotics | No | Yes | |
| Aspirin, Ibuprofen, or Tylenol | No | Yes | |
| Codeine, Valium, or other sedatives | No | Yes | |
| Latex | No | Yes | |
| Metals | No | Yes | |
| Other (please specifiy) | No | Yes | |

Tobacco, Alcohol, and other Drugs

| | | |
|---|---|---|
| Do you use tobacco? If yes, circle type: *smoke* *dip* *chew*<br>How much per day? *Less than half a pack* *half a pack to 1 pack* *More than 1 pack*<br>For how long? | No | Yes |
| Do you want to quit using tobacco? | No | Yes |
| Do you consume alcohol?<br>If yes, approximately how many alcoholic beverages per week? | No | Yes |
| Do you use any other mood altering drugs (illicit/illegal/street drugs) other than those previously listed? | No | Yes |

Weight and Diet considerations

| Weight | Meals per day | Dietary Restrictions | Food Allergies | |
|---|---|---|---|---|
| | | | | |
| Do you consume grapefruit juice, grapefruits, or grapefruit extract? | | | No | Yes |

**ADULT DENTAL HEALTH ASSESSMENT**

When was your last dental visit?

| Question | | |
|---|---|---|
| Are you apprehensive about dental treatment? | No | Yes |
| Have you had previous bad dental experiences? | No | Yes |
| Do you gag easily? | No | Yes |
| Do you wear dentures or partials? | No | Yes |
| Does food catch between your teeth? | No | Yes |
| Do you have difficulty chewing your food? | No | Yes |
| Do you chew on only one side of your mouth? | No | Yes |
| Do you avoid brushing any part of your mouth because of pain? | No | Yes |
| Do your gums bleed easily? | No | Yes |
| Do your gums bleed when you floss? | No | Yes |
| Do your gums feel swollen or tender? | No | Yes |
| Have you ever noticed slow healing sores in or about your mouth? | No | Yes |
| Are your teeth sensitive? | No | Yes |
| Do you feel twinges of pain when eating? | No | Yes |
| Hot foods or liquids | No | Yes |
| Cold foods or liquids | No | Yes |
| Sours | No | Yes |
| Sweets | No | Yes |
| Do you take fluoride supplements? | No | Yes |
| Are you dissatisfied with the appearance of your teeth? | No | Yes |
| Do you to prefer to save your teeth? | No | Yes |
| Do you want complete/comprehensive dental care? | No | Yes |

| Question | | |
|---|---|---|
| Does your jaw make noise so that it bothers you or others? | No | Yes |
| Do you clench or grind your jaws frequently? | No | Yes |
| Do your jaws ever feel tired? | No | Yes |
| Does your jaw get stuck so that you cannot open freely? | No | Yes |
| Does your jaw hurt when you chew or open wide to take a bite? | No | Yes |
| Do you have earaches or pain in front of the ears? | No | Yes |
| Do you have any jaw symptoms or headaches upon waking in the morning? | No | Yes |
| Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? | No | Yes |
| Do you find jaw pain or discomfort extremely frustrating or depressing? | No | Yes |
| Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, or antidepressants)? | No | Yes |
| Do you have a temporomandibular (jaw) disorder (TMD)? | No | Yes |
| Do you have pain in the face, cheeks, jaws, joints, throat, or temples? | No | Yes |
| Are you unable to open your mouth as far as you want? | No | Yes |
| Are you aware of an uncomfortable bite? | No | Yes |
| Have you had trauma to your jaw? | No | Yes |
| Are you a habitual gum chewer? | No | Yes |
| Do you experience severe dry-mouth? | No | Yes |
| Do you feel you have bad breath no matter what you do? | No | Yes |
| Are you dissatisfied with the color or whiteness of your teeth? | No | Yes |
| Do you desire straighter teeth? | No | Yes |
| How often do you:<br>Brush?____________________<br>Floss?_____________________ | | |

Is there anything we can do to make your appointments more comfortable? ________________________________________

________________________________________________________________________________

What is your ultimate goal regarding your dental health? ________________________________________________

________________________________________________________________________________

Please let us know any other information that may help us to provide you with optimum dental care: ___________________

________________________________________________________________________________

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes to my health and medication.*

| | | |
|---|---|---|
| ______________________________ | ____________________________ | __________________ |
| *Patient (Print Name)* | *Patient Signature* | *Date* |
| ______________________________ | ____________________________ | __________________ |
| *Doctor (Print Name)* | *Doctor Signature* | *Date* |