MEDICAL HEALTH HISTORY (ADULT)

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Do you have or have you had any of the following?

Cancer or tumor ❑ yes ❑ no
Heart ailment or angina ❑ yes ❑ no
Heart murmur, mitral valve prolapse, heart defect ❑ yes ❑ no
Rheumatic fever or rheumatic heart disease ❑ yes ❑ no
Artificial joint or valve ❑ yes ❑ no
High or low blood pressure ❑ yes ❑ no
Pacemaker ❑ yes ❑ no
Tuberculosis or other lung problems ❑ yes ❑ no
Kidney disease ❑ yes ❑ no
Hepatitis or other liver disease ❑ yes ❑ no
Alcoholism ❑ yes ❑ no
Blood transfusion ❑ yes ❑ no
Diabetes ❑ yes ❑ no
Neurologic condition ❑ yes ❑ no
Epilepsy, seizures, or fainting spells ❑ yes ❑ no
Emotional condition ❑ yes ❑ no
Arthritis ❑ yes ❑ no
Herpes or cold sores ❑ yes ❑ no
AIDS or HIV positive ❑ yes ❑ no
Migraine headaches or frequent headaches ❑ yes ❑ no
Anemia or blood disorders ❑ yes ❑ no
Abnormal bleeding after extractions, surgery, or trauma ❑ yes ❑ no
Hayfever or sinus trouble ❑ yes ❑ no
Allergies or hives ❑ yes ❑ no
Asthma ❑ yes ❑ no
Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- Latex (Rubber) materials ❑ yes ❑ no
- Penicillin or other antibiotics ❑ yes ❑ no
- Local anesthetics ("Novocaine") ❑ yes ❑ no
- Codeine or other narcotics ❑ yes ❑ no
- Sulfa drugs ❑ yes ❑ no
- Barbiturates, sedatives, or sleeping pills ❑ yes ❑ no
- Aspirin ❑ yes ❑ no
- Other:_____

Are you taking any of the following?

- Aspirin ❑ yes ❑ no
- Anticoagulants (blood thinners) ❑ yes ❑ no
- Antibiotics or sulfa drugs ❑ yes ❑ no
- High blood pressure medicine ❑ yes ❑ no
- Antidepressants or tranquilizers ❑ yes ❑ no
- Insulin, Orinase, or other diabetes drug ❑ yes ❑ no
- Nitroglycerin ❑ yes ❑ no
- Cortisone or other steroids ❑ yes ❑ no
- Osteoporosis (bone density) medicine ❑ yes ❑ no

Other: _____

_____

Women:
May be pregnant ❑ yes ❑ no
Expected delivery date: _____
Taking hormones or contraceptives ❑ yes ❑ no

DENTAL HEALTH HISTORY

Are you concerned about having dental treatment ❑ yes ❑ no
Have you have problems with previous dental treatment ❑ yes ❑ no
Do you gag easily ❑ yes ❑ no
Do you wear dentures ❑ yes ❑ no
Does food catch between your teeth ❑ yes ❑ no
Do you have difficulty chewing your food ❑ yes ❑ no
Do you chew on only one side of your mouth ❑ yes ❑ no
Do you avoid brushing any part of your mouth because of pain ❑ yes ❑ no
Do your gums bleed easily ❑ yes ❑ no
Do your gums bleed when you floss ❑ yes ❑ no
Do your gums feel swoolen or tender ❑ yes ❑ no
Have your ever noticed slow-healing sores in your mouth ❑ yes ❑ no
Are your teeth sensitive ❑ yes ❑ no

Do you feel twinges of pain when your teeth come in contact with:
Hot foods or liquids ❑ yes ❑ no
Cold foods or liquids ❑ yes ❑ no
Sours ❑ yes ❑ no
Sweets ❑ yes ❑ no

Do you take fluoride supplements ❑ yes ❑ no
Are you dissatisfied with the appearance of your teeth ❑ yes ❑ no
Do you prefer to save your teeth ❑ yes ❑ no
Do you want complete dental care ❑ yes ❑ no
How often do you brush _____
How often do you floss _____
Does your jaw make noise so that it bothers you or others ❑ yes ❑ no

Do you clench or grind your jaws frequently ❑ yes ❑ no
Do your jaws every feel tired ❑ yes ❑ no
Does your jaw get stuck so that you can't open feel ❑ yes ❑ no
Does it hurt when you chew or open wide to take a bite ❑ yes ❑ no
Do you have earaches or pain in front of the ears ❑ yes ❑ no
Do you have any jaw symptoms or headaches upon waking in the morning ❑ yes ❑ no

Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities ❑ yes ❑ no
Do you find jaw pain or discomfort extremely frustrating or depressing ❑ yes ❑ no
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants) ❑ yes ❑ no
Do you have temporomandibular (jaw) disorder (TMD) ❑ yes ❑ no
Have you have a blow (trauma) to your jaw ❑ yes ❑ no
Are you a habitual gum chewer ❑ yes ❑ no

Please tell us more about any questions you answered yes to above: _____

_____

_____

Name and phone number of your primary care physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

I understand the importance of being truthful about my medical and dental history and realize that incomplete information may have an adverse (negative) effect on my treatment and possibly my health. To the best of my knowledge, the information above is complete and accurate.

Signature of patient (or parent) _____ Date _____

Printed Name of patient (or parent) _____

Witness: _____