ADULT MEDICAL HISTORY Today's Date_____

Name_____Height____Weight____Age_____Birthdate_____
Physician'sName_____City/State_____
Date of Last Physical Exam_____ Reason_____
Major Surgery or Stay in Hospital for_____
Women: ☐ Pregnant ____weeks Due Date: _____ ☐Nursing ☐Using Oral Contraceptives
☐ My Physician recommends that I take prophylactic antibiotics before dental procedures
Current Medications and Supplements: _____

Please ☐and **underline or circle specific** health issues that you have now or had in the past. Clarify when appropriate.

☐Heart Disease/Heart attack
☐Pace Maker/Defibrillator
☐Chest pain/Angina
☐Heart Murmur/Defects/Mitral Valve prolapse
☐Infective Endocarditis/Rheumatic Fever
☐High Blood Pressure/Low Blood Pressure
☐Artificial joints: Hip/Knee/Shoulder/Other
☐Blood Vessel Disease
☐Stroke/TIA/Blood Clots
☐Bruise or bleed easily/Hemophilia
☐Fainting/dizziness/vertigo
☐Asthma/Other lung disease
☐TB (Tuberculosis)
☐Snoring/Sleep Apnea
☐Grind or Clench Teeth/Painful jaw joints
☐Headaches (frequent)/Migraines
☐Arthritis/rheumatoid/osteoarthritis
☐Osteoporosis/Bisphosphonates
☐Musculoskeletal problems/ Back/Neck
☐Epilepsy/Neurologic disorder
☐Parkinson's disease
☐Fibromyalgia
☐Multiple Sclerosis/Muscular Dystrophy
☐Thyroid Disease
☐Steroids/Frequent/Long Term
☐Diabetes/ Type I / Type II
☐Kidney disease/ impaired function
☐Liver Disease/Cirrhosis
☐Stomach/GI/Ulcers/ Colitis/Celiac disease
☐Heart Burn/Acid reflux/Esophageal reflux
☐Bulimia/Anorexia
☐Gum Disease/loose teeth/bone loss
☐Dry Mouth/Sjogren's syndrome
☐Mouth Ulcers/Cold Sores
☐Autoimmune disease/Lupus
☐Smoking/Chewing tobacco
☐Eye problems/ Ear problems
☐ADHD/ADD
☐Depression/Anxiety/Panic attacks
☐Mental impairment
☐Psychiatric problems
☐Dementia/Alzheimer's
☐Alcoholism/Drug addiction
☐Prescription pain meds (dependent use or abuse)
☐Recreational drug use
☐Pancreatitis
☐HPV (Human Papilloma Virus)
☐Hepatitis, Type: A B C D
☐HIV+/AIDS
☐Herpes Type 2/Sexually Transmitted Disease
☐Cancer, malignant_____
☐Tumors, benign_____
☐Radiation/ Chemotherapy

ALLERGIES:

☐Penicillin
☐Clindamycin
☐Aspirin/Ibuprofen/NSAIDS
☐Tylenol
☐Codeine
☐Latex
☐Dental Anesthetics
☐Metals
☐Foods
☐Hay fever, seasonal

Other Allergies or Health Issues:_____
_____
_____
_____

I have answered these questions to the best of my ability. I will notify the office of any changes.

Patient or Legal Guardian Signature_____Date_____