Patient Name: _____ **Birth Date:** _____

Today's Date: _____ **Phone#:** _____

Adult Medical History

Please circle YES or NO if you have any of the following disease, conditions or procedures

Y N Abnormal bleeding/Hemophilia
Y N ADD/ADHD
Y N Allergy
Y N Anemia
Y N Anxiety
Y N Arthritis/Inflammatory/Rheumatism
Y N Asthma/Hay fever
Y N Autism
Y N Cancer/Chemotherapy/radiation
Y N Chest pain upon exertion
Y N Venereal disease
Y N Diabetes (Type ____)
Y N Digestive (Ulcers/Colitis)
Y N Epilepsy/fainting/seizures
Y N Heart murmur/heart disease
Y N Heart attack/AFIB
Y N Hepatitis (Type___)
Y N High/low blood pressure
Y N Hives/skin rash
Y N Immune Defic (AIDS/HIV/ARC)
Y N Jaw problems TMJ/TMD
Y N Jaundice/Liver disease
Y N Kidney/Organ Problems
Y N Migraines
Y N Pacemaker
Y N Rheumatic fever
Y N Shortness of breath
Y N Sinus trouble
Y N Stroke
Y N Surgeries/operations
Y N Tuberculosis

If YES explain: _____

Do you have any disease or condition not listed above that we should know about? _____

Y N Have you had an orthopedic total joint (e.g. hip/knee/elbow/finger) replacement? If yes, what joint was replaced, when was it replaced and have you had any complications? _____

Y N Have you taken or are you scheduled to begin taking ORAL bisphosphonoates (e.g. Alendronate/Fosamax,Ibandronat/Boniva or Risedronat/Actonel) OR INTRAVENOUS bisphosphonates (e.g.Pamidronate/Aredia or Zoledronic Acid/Zometa)? If yes, which drug, how long and for what condition? _____

Y N In the last 2 years, have you taken or are you now taking steroids (e.g. cortisone)? If yes, which steroid and what dose?

_____

Y N Do you wear contact lenses **Y N** Are you pregnant? If yes, how many months? _____

Y N Have you ever had any serious complications associated with dental treatment? _____

Y N Have you ever had abnormal bleeding associated with extractions, surgery or trauma?

Physician name: _____ Phone: _____

Current Medications

Please list all medications that you are taking, including over the counter meds, supplements etc. as well prescription medications with dosage and frequency

_____

_____

_____

_____

_____

_____

_____

Allergies

Y N Local anesthetics_____
Y N Penicillin or other antibiotics _____
Y N Sulfa drugs **Y N** Sedatives or sleeping pills _____
Y N Aspirin **Y N** Iodine **Y N** Latex allergy
Y N Codeine or other narcotics _____
Y N Other _____

Y N Do you use tobacco products? If yes, please specify type and how many per day:

_____

Y N Do you use drugs or other substances for recreational purposes? If yes, please specify type and how often do you use?

_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes.

_____ _____

Signature of Patient or Guardian Date Signature of Dentist Date