



Adult Medical and Dental History

Patient Name _____ D.O.B. _____

Emergency Contact (Name/Phone #) _____

Medical History

1. Physician _____ Address _____

2. When was your last physical examination _____

3. Are you under the care of a physician? Yes No

If yes, for what reason(s)? _____

4. Are you presently taking any medications/drugs/pills/herbals/supplements? Yes No

If yes, please list: _____

5. (Women) Is there a chance you are pregnant? Yes No

If yes, anticipated due date? _____

6. Do you take oral contraceptives? Yes No

7. Are you allergic/sensitive to: None Codeine Penicillin Local Anesthetic Latex Pine Nuts Dyes

Other: Please list _____

8. Do you smoke, chew tobacco, or use E-cigarettes? Yes No

If yes, please indicate which one(s), daily frequency, and how long? _____

9. Do you have Diabetes? Yes No

If yes, please indicate: Type 1 Type 2 Prediabetes

10. Do you have, or have you ever had:

- | | | | |
|---------------------|--|------------------------------------|--|
| Heart pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney trouble/Dialysis..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Oral herpetic lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis/treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis (Type __) | <input type="checkbox"/> Yes <input type="checkbox"/> No | w/Bisphosphonates | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HIV positive/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sinus trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually transmitted disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid problem | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ulcers/GERD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis or Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial heart valve/stent/graft | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial joint replacements | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemical dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy/radiation..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital heart defects | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Corticosteroid treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive or prolonged bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing impaired | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

11. Do you take pre-medication for any dental work? Yes No

If you pre-medicate, what medication? _____
12. Have you had any other serious illness, hospitalization or accident? _____ Yes No
If yes, please explain: _____

Dental History

1. Previous Dentist _____
Address _____
2. When did you last visit a dentist?
When was your last cleaning? _____
X-rays taken? Yes No
If yes, Full Mouth Series Bitewings Panoramic
What was done at your last visit?
Has any dental treatment been recommended to you that you have not yet had done? Yes No
If yes, please explain _____
3. Are you aware of any dental problems Yes No
If yes, please explain:
4. Please rate the present condition of your mouth:Poor 1 2 3 4 5 6 7 8 9 10 Excellent
5. Have you ever been treated for gum disease? Yes No
If yes, what was done? _____
6. Do you have well water? Yes No Not Sure
7. Is your water fluoridated? _____ Yes No Not Sure
8. Are your teeth sensitive to: Nothing Sweet Cold Heat Pressure
9. Please rate the appearance of your smile: Poor 1 2 3 4 5 6 7 8 9 10 Excellent
10. Would you like a whiter smile? Yes No Not Sure
11. Would you like straighter teeth? _____ Yes No Not Sure
12. Have you had your teeth straightened/worn braces? _____ Yes No
13. Are you concerned with bad breath (halitosis)? Yes No
14. Are you concerned with snoring or sleep apnea? _____ Yes No
15. Are you concerned with grinding or clenching your teeth (bruxism)? Yes No
16. Do you wear a bite guard? _____ Yes No
17. Are you aware of possible TMJ problems?
(Does your jaw joint make noise, lock up, or create pain?) _____ Yes No
18. Are you interested in sleep/sedation dentistry? _____ Yes No
19. Is there anything else that would be valuable for your dentist to know to best care for you?

How did you hear about us?

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist in the case of referral.
- I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

Patient Signature _____ Date _____
(Parent/Guardian)

Dentist Signature _____ Date _____