Medical History for Adolescents and Adults (rev. November 2017)(Copy)

Patient Name: Birth Date: Date Created:

Are you under a physician's care? If yes, for what reason? ○ Yes ○ No If yes

Are you taking any medications, pills, or drugs? If so, please list below and include reason for taking. ○ Yes ○ No

Are you allergic to any of the following?

☐ Penicillin ☐ Non-precious metals ☐ Latex ☐ Sulfa drugs
☐ Tree nuts

Other allergies? ○ Yes ○ No If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant ☐ Nursing? ☐ Taking oral contraceptives?

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

Alzheimer's	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Liver Disease	○ Yes ○ No
Anaphylaxis or Hives	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Anemia	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No
Angina	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Pain in Jaw Joint(s)	○ Yes ○ No
Arthritis	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Hepatitis A,B,orC	○ Yes ○ No	Parkinson's Disease	○ Yes ○ No
Bulimia or Anorexia	○ Yes ○ No	Herpes	○ Yes ○ No	Radiation to Head/Neck	○ Yes ○ No
Chemotherapy	○ Yes ○ No	High Anxiety or Depression	○ Yes ○ No	Shingles	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Sinus Problems	○ Yes ○ No
Diabetes	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Stomach Ulcers/GERD	○ Yes ○ No
Drug addiction	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Stroke	○ Yes ○ No
Epilepsy or Seizures	○ Yes ○ No	Kidney problems or Dialysis	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Leukemia	○ Yes ○ No	Tuberculosis	○ Yes ○ No

Cancer? If yes, please give type. ○ Yes ○ No If yes

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Does your physician require you to have antibiotics prior to dental treatment? If yes, please list condition and physician. ○ Yes ○ No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing disphosphonates? ○ Yes ○ No If yes

Do you use tobacco? Please list type and frequency of use. ○ Yes ○ No If yes

Please list the name of your primary care physician and any specialists you currently see.

Please give any other information you feel is important for the dentist to know.

Signature of Patient, Parent or Guardian:

X Date:_____