Medical History Info for Adult Patient

updated 2015

Patient Name _____

General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor **Name** of Medical Physician_____ **Date** of last physical exam: _____

Antibiotics: Have you been told that you need to take antibiotics before dental treatment? Y N Reason _____

Before some dental treatments, patients who have certain heart conditions and those with artificial joints take antibiotics. These people may be at risk of developing an infection in the heart or at the site of the artificial joint. Antibiotics reduce this risk. If you are not sure, we can ask your M.D. with your permission.

Medical conditions: Do you history of, or conditions related to, any of the following? *(CHECK ALL THAT APPLY)*

GENERAL CONDITIONS

- Alzheimer Y N
- Arthritis Y N
- Cancer: (TYPE _____) Y N
- Diabetes TYPE I OR II Y N
- Epilepsy/Seizures Y N
- Kidney/bladder disease Y N
- Liver disease or Jaundice Y N
- Osteoporosis Y N
- Stomach problems/ulcers Y N
- Stroke (DATE_____) Y N
- Thyroid/adrenal disease Y N

HEART OR LUNG

- Asthma Y N
- Emphysema Y N
- Heart disease Y N
- Heart murmur Y N
- HIGH / LOW blood pressure Y N
- Mitral valve prolapse Y N
- Rheumatic fever Y N
- Tuberculosis Y N

HEAD

- Ear aches or ringing Y N
- Glaucoma or eye disease Y N
- Hay fever or allergies Y N
- Head/Brain injury Y N
- Headaches/migraines Y N
- Sinus problems Y N

HEMATOLOGICAL (blood-related)

- Anemia Y N
- Bleeding (prolonged) Y N
- Hemophilia Y N

PSYCHOLOGICAL/EMOTIONAL

- Anxiety Y N
- Depression Y N
- Mental health disorder Y N
- Other _____ Y N

WOMEN

- Pregnant: DUE DATE _____ Y N
- Nursing Y N
- Taking birth control pills? Y N
- Hormone replacement therapy Y N

INFECTIOUS

- Hepatitis (TYPE _____) Y N
- HIV infection (AIDS) Y N
- Herpes (mouth) Y N

SUBSTANCE USE/ABUSE

- Recreational drug use Y N
- Tobacco/Cigarette use Y N
- Alcohol Abuse Y N

OTHER CONDITIONS

- Back pain Y N
- Bruise easily Y N
- Cough-persistent or bloody Y N
- Dry mouth or excessive thirst Y N
- Fainting or Dizziness Y N
- Frequent vomiting/nausea Y N
- Shortness of breath Y N
- Skin disease/rash Y N
- Snoring/sleep apnea/other problems Y N
  IF YES, do you use one of the following:
  ☐CPAP ☐SLEEP APPLIANCE ☐NONE
- Swollen ankles Y N
- Weight loss (significant) Y N

Other: _____

If any boxes checked, please describe further:_____

_____

Medications: Are you taking any medications? Y N

Please list medication, dose & reason:

_____

_____

_____

_____

_____

_____

_____

_____

(Please use a separate paper if there are too many to list here)

Treatments: Have you ever had any of the following? *If yes, indicate **DATES***

- Artificial Heart Valves Y N _____
- Blood transfusion Y N _____
- Chemotherapy/Radiation Y N _____
- Contact lenses Y N _____
- Cortisone/steroid Y N _____
- Joint Replacement Y N _____
  SPECIFY _____
- Pacemaker Y N _____
- Transplants Y N _____
  SPECIFY _____

Allergies: *Are you allergic to any of the following?*

Medications or drugs

- Aspirin Y N
- Codeine Y N
- Demerol Y N
- Darvon Y N
- Percodan Y N
- Iodine Y N
- Erythromycin Y N
- Penicillin Y N
- Sulfa Y N
- Tetracycline Y N
- Valium Y N
- Vicodin Y N

Latex/Rubber Y N

Local Anesthetics Y N _____

Jewelry/Metals Y N

Other _____ Y N

*Are you taking or have you ever taken **bisphosphonates** for osteoporosis, multiple myeloma or other cancers?*
(IE. RECLAST, FOSAMAX, ACTONEL, BONIVA, AREDIA, ZOMETA)

N Y dates _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and is my responsibility to inform this office of any changes to my medical status.

X_____ _____
Patient's Signature *Date*

_____ _____
Dentist Review *Date*

RE-EVALUATION OF ORIGINAL MEDICAL HISTORY

At every visit, you will be asked to update your medical history. A complete medical history is essential and important for safe and effective treatment. This form is completely confidential, and will be used only for dental and medical reasons.

Date	Changes?	If yes, what changes? Include any serious illness, surgery or hospitalizations	Initials	BP	HR	Reviewed by
	Y N		X	/	bpm	
	Y N		X	/	bpm	
	Y N		X	/	bpm	
	Y N		X	/	bpm	
	Y N		X	/	bpm	
	Y N		X	/	bpm	
	Y N		X	/	bpm	