

# Adult Medical History

PATIENT FULL NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PREFERRED PRONOUNS (if applicable) \_\_\_\_\_ PREFERRED NAME (if applicable) \_\_\_\_\_

NAME OF MEDICAL PHYSICIAN \_\_\_\_\_ DATE OF LAST MEDICAL EXAM \_\_\_\_\_

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (check box for no change) ☐

|                                                     |                                                            |                                                            |                                                                |
|-----------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> ABNORMAL BLEEDING          | <input type="checkbox"/> CONGENITAL HEART DEFECT           | <input type="checkbox"/> HIGH BLOOD PRESSURE               | <input type="checkbox"/> PREGNANCY OR POSSIBILITY OF PREGNANCY |
| <input type="checkbox"/> AIDS/HIV                   | <input type="checkbox"/> CORONARY ARTERY STENTS            | <input type="checkbox"/> HISTORY OF INFECTIVE ENDOCARDITIS | <input type="checkbox"/> RADIATION THERAPY                     |
| <input type="checkbox"/> ANEMIA                     | <input type="checkbox"/> DEEP VEIN THROMBOSIS/ BLOOD CLOTS | <input type="checkbox"/> IRREGULAR HEARTBEAT/ARRHYTHMIA    | <input type="checkbox"/> RECENT WEIGHT LOSS                    |
| <input type="checkbox"/> ANGINA/CHEST PAIN          | <input type="checkbox"/> DEMENTIA/ALZHEIMER'S DISEASE      | <input type="checkbox"/> JAUNDICE                          | <input type="checkbox"/> RHEUMATIC FEVER                       |
| <input type="checkbox"/> ARTHRITIS                  | <input type="checkbox"/> DIABETES                          | <input type="checkbox"/> JAW PAIN                          | <input type="checkbox"/> SEIZURES/EPILEPSY                     |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE     | <input type="checkbox"/> DIALYSIS                          | <input type="checkbox"/> KIDNEY DISEASE                    | <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE          |
| <input type="checkbox"/> ASTHMA                     | <input type="checkbox"/> EMPHYSEMA/COPD                    | <input type="checkbox"/> LIVER DISEASE                     | <input type="checkbox"/> SHORTNESS OF BREATH                   |
| <input type="checkbox"/> AUTOIMMUNE DISEASE         | <input type="checkbox"/> FAINTING/DIZZINESS                | <input type="checkbox"/> LOW BLOOD PRESSURE                | <input type="checkbox"/> SLEEP APNEA                           |
| <input type="checkbox"/> BLOOD DISEASE/TRANSFUSIONS | <input type="checkbox"/> GERD/ACID REFLUX                  | <input type="checkbox"/> MENTAL HEALTH CONDITION           | <input type="checkbox"/> STOMACH TROUBLE/ULCER                 |
| <input type="checkbox"/> BLOOD THINNERS             | <input type="checkbox"/> HAY FEVER                         | <input type="checkbox"/> MITRAL VALVE PROLAPSE             | <input type="checkbox"/> STROKE/TIA                            |
| <input type="checkbox"/> BREATHING PROBLEMS         | <input type="checkbox"/> HEART ATTACK                      | <input type="checkbox"/> MULTIPLE SCLEROSIS                | <input type="checkbox"/> SUBSTANCE USE DISORDER                |
| <input type="checkbox"/> BRUISE EASILY              | <input type="checkbox"/> HEART DISEASE                     | <input type="checkbox"/> ORGAN TRANSPLANT                  | <input type="checkbox"/> SWOLLEN ANKLES                        |
| <input type="checkbox"/> CANCER                     | <input type="checkbox"/> HEART MURMUR                      | <input type="checkbox"/> OSTEOPOROSIS                      | <input type="checkbox"/> THYROID PROBLEMS                      |
| <input type="checkbox"/> CHEMOTHERAPY               | <input type="checkbox"/> HEMOPHILIA                        | <input type="checkbox"/> PACEMAKER                         | <input type="checkbox"/> TUBERCULOSIS                          |
| <input type="checkbox"/> COLD SORES/FEVER BLISTERS  | <input type="checkbox"/> HEPATITIS A B C                   | <input type="checkbox"/> PARKINSON'S DISEASE               |                                                                |

OTHER (PLEASE DESCRIBE):

HAVE YOU BEEN HOSPITALIZED FOR ANY OPERATIONS OR SERIOUS ILLNESSES WITHIN THE LAST 5 YEARS? ☐ Yes ☐ No If yes, please explain:

BONE/OSTEOPOROSIS MEDICATIONS: Have you ever taken or are you currently taking medications for osteoporosis or other bone conditions including bisphosphonates? (ex. Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Reclast (zoledronic acid), Prolia (denosumab), Xgeva (denosumab) ☐  
No ☐ Yes ☐ Unsure

HAVE YOU HAD A JOINT REPLACEMENT OR IMPLANT? ☐ Yes ☐ No

If so, when? \_\_\_\_\_

## ALLERGIES

☐ Aspirin/NSAIDs

☐ Penicillin/amoxicillin

☐ Other antibiotics (sulfa drugs)

Please list:

☐ Local anesthetic

☐ Iodine

☐ Latex

☐ Sedatives

☐ Other:

ARE YOU CURRENTLY TAKING PRESCRIPTION MEDICATION(S)? ☐ Yes ☐ No

PLEASE LIST:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(you may also provide copy of your medication list to the staff)

## AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners. I agree to notify the office of any health changes that may occur during the year.

SIGNATURE OF PARENT OF GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_