ADULT MEDICAL HISTORY

Doctor's Notes

1. Your physician's name, phone, address ______________________________

2. Have you ever had a serious illness or operation?........ YES NO
If yes, explain ______________________________

3. When was your last complete physical exam? ______________________________

4. Are you currently being treated/monitored for a specific condition by your physician?... YES NO
If yes, why? ______________________________

5. Are you taking any medication, including birth control?........ YES NO
Please list: ______________________________

6. Do you have any known allergies?........ YES NO

7. Are you allergic to any specific medications or substances?........ YES NO

8. Do you have any problem with penicillin, antibiotics, or anesthetics?........ YES NO

9. Have you been treated for or have you been told you might have heart disease?........ YES NO

10. Have you ever had a stroke?........ YES NO

11. Do you have a pacemaker or an artificial heart valve?........ YES NO

12. Are you aware of any heart murmurs?........ YES NO

13. Have you ever had rheumatic fever?........ YES NO

14. Have you ever been advised to be premedicated with antibiotics prior to dental treatment?........ YES NO

15. Have you ever had surgery, radiation treatment, or chemo therapy treatment for a tumor, growth, or other condition?........ YES NO

16. Do you have high or low blood pressure?........ YES NO

17. Do you have inflammatory diseases, such as arthritis, rheumatism, or lupus?........ YES NO

18. Do you have any artificial joints or prosthesis?........ YES NO

19. Do you have any blood disorders, such as anemia, leukemia, etc.?........ YES NO

20. Have you ever bled excessively after being cut or injured?........ YES NO

21. Do you have any stomach problems?........ YES NO

22. Do you have any kidney problems?........ YES NO

23. Do you have any liver problems?........ YES NO

24. Are you diabetic, or borderline diabetic?........ YES NO

25. Do you have asthma?........ YES NO

26. Do you have epilepsy or seizure disorders?........ YES NO

27. Have you ever had venereal disease?........ YES NO

28. Do you have AIDS or have you tested positive for HIV?........ YES NO

29. Have you ever had hepatitis?........ YES NO
If yes, what type? ______________________________

30. Have you ever had a blood transfusion?........ YES NO

31. Have you ever had TB?........ YES NO

32. Do you use any tobacco products?........ YES NO
What type of product & how much? ____________ For how long? ______

33. Do you consume alcoholic beverages?........ YES NO

34. Are you pregnant or suspect that you may be?........ YES NO

35. Do you have any disease, condition, or problem not listed?........ YES NO
If yes, explain ______________________________

36. Is there anything else we should know about your health that we have not covered?.... YES NO
If yes, explain ______________________________

37. Would you like to speak to the Doctor privately about any concerns?........ YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's Signature ______________________________ Date ________

Dentist's Signature ______________________________ Date ________

ANEST.

MED. ALERT