



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: _____

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 Last HbA1c date and level: _____

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

- Abnormal blood pressure..... Yes No
- Anemia Yes No
- Arthritis Yes No
- Artificial heart valve/stent/graft..... Yes No
- Artificial joint replacements Yes No
- Asthma Yes No
- Cancer Yes No
- Chemical dependency Yes No
- Chemotherapy/radiation Yes No
- Congenital heart defects Yes No
- Corticosteroid treatment Yes No
- Epilepsy/seizures Yes No
- Excessive or prolonged bleeding Yes No
- Fainting spells Yes No
- Glaucoma Yes No
- Hearing impaired Yes No
- Heart murmur Yes No

- Heart pacemaker Yes No
- Heart surgery Yes No
- Heart trouble Yes No
- Hepatitis (Type __) Yes No
- HIV positive/AIDS Yes No
- Jaundice Yes No
- Kidney trouble/Dialysis Yes No
- Leukemia Yes No
- Oral herpetic lesions Yes No
- Osteoporosis/treatment w/Bisphosphonates Yes No
- Psychiatric care Yes No
- Rheumatic fever Yes No
- Sexually transmitted disease Yes No
- Sinus trouble Yes No
- Stroke Yes No
- Thyroid problem Yes No
- Tuberculosis or Lung Disease Yes No
- Ulcers/GERD Yes No

11. Do you take pre-medication for anything? Yes No

If you pre-medicate, what for? _____

12. Have you had any other serious illness, hospitalization or accident? Yes No

If yes, please explain: _____

(Over Please)

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Dental History

1. Former 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? _____
 Why did you leave that dentist? _____
 Has any dental treatment been recommended to you that you have not had done? _____
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
7. Is your water fluoridated? Yes No
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
11. Would you like straighter teeth?..... Yes No
12. Have you had your teeth straightened/worn braces? Yes No
13. Are you concerned with bad breath (malodor)? 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? _____

- 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.
- 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 _____