

Alliance for Dental Care

ADULT MEDICAL HISTORY

PATIENT'S NAME _____
Last
First
Initial
Date of Birth

CIRCLE THE APPROPRIATE ANSWER

COMMENTS

- | | | | | |
|---|-----|----|--|--|
| 1. Physician's Name _____
Address _____ | | | | |
| 2. Are you under a physician's care? | YES | NO | | |
| Since when _____ Why? _____ | | | | |
| 3. When was your last complete physical exam? _____ | | | | |
| 4. Are you taking any medication? | YES | NO | | |
| 5. Do you routinely take health related substances? | YES | NO | | |
| 6. Are you allergic to any medications or substances? | YES | NO | | |
| 7. Do you have any other allergies? | YES | NO | | |
| 8. Do you have any problems with penicillin, antibiotics, anesthetics, or any other medications? | YES | NO | | |
| 9. Are you sensitive to any metals or latex? | YES | NO | | |
| 10. Are you pregnant or suspect that you may be? | YES | NO | | |
| 11. Do you use any birth control medications? | YES | NO | | |
| 12. Have you ever been treated for or been told you might have a heart disease? | YES | NO | | |
| 13. Do you have a pacemaker or an artificial heart valve implant? | YES | NO | | |
| 14. Have you ever had rheumatic fever? | YES | NO | | |
| 15. Are you aware of any heart murmurs? | YES | NO | | |
| 16. Do you have high or low blood pressure? | YES | NO | | |
| 17. Have you ever had a serious illness or major surgery? | YES | NO | | |
| If so, explain _____ | | | | |
| 18. Have you ever had radiation treatment, chemo treatment for a tumor, growth, or other condition? | YES | NO | | |
| 19. Do you have inflammatory diseases, such as arthritis or rheumatism? | YES | NO | | |
| 20. Do you have any artificial joints/prosthesis? | YES | NO | | |
| 21. Do you have any blood disorders, such as anemia, leukemia, etc? | YES | NO | | |
| 22. Have you ever bled excessively after being cut or injured? | YES | NO | | |
| 23. Do you have any stomach problems? | | | | |
| 24. Do you have any kidney problems? | YES | NO | | |
| 25. Do you have any liver problems? | YES | NO | | |
| 26. Are you diabetic? | YES | NO | | |
| 27. Do you have asthma? | YES | NO | | |
| 28. Do you have epilepsy or seizure disorders? | YES | NO | | |
| 29. Do you or have you had venereal disease? | YES | NO | | |
| 30. Have you tested HIV positive? | YES | NO | | |
| 31. Do you have AIDS? | YES | NO | | |
| 32. Have you had or do you test positive for hepatitis? | YES | NO | | |
| 33. Do you or have you had T.B.? | YES | NO | | |
| 34. Do you smoke, chew, use snuff, or any other forms of tobacco? | YES | NO | | |
| 35. Do you consume alcoholic beverages? | YES | NO | | |
| 36. Do you habitually use controlled substances? | YES | NO | | |
| 37. Have you had psychiatric treatment? | YES | NO | | |
| 38. Do you have any disease, condition, or problem not listed? If so, explain _____ | YES | NO | | |
| 39. Is there anything else we should know about your health that we have not covered in this form? _____ | YES | NO | | |
| 40. Would you like to speak to the Doctor privately about any problem? | YES | NO | | |

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ Date _____

DENTIST'S SIGNATURE _____ Date _____