Family & Cosmetic Dentistry
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Adult Medical History

Patient Name:	**Preferred Name:**
Age:	**Name of Physician and their specialty:**
Phone Number:	**Most Recent examination:**
Purpose:	

What is your estimate of your general health?
❑ Excellent ❑ Good ❑ Fair ❑ Poor

Medical History

Have you ever had an allergic reaction to:

Aspirin, ibuprofen, acetaminophen	❑ Yes	❑ No	**Penicillin**	❑ Yes	❑ No
Erythromycin	❑ Yes	❑ No	**Tetracycline**	❑ Yes	❑ No
Codeine	❑ Yes	❑ No	**Local anesthetic**	❑ Yes	❑ No
Fluoride	❑ Yes	❑ No	**Metals (Gold, Nickel)**	❑ Yes	❑ No
Latex	❑ Yes	❑ No	**Other**	❑ Yes	❑ No

Do you have or have you ever had?

Hospitalization for illness or injury	❑ Yes	❑ No	**Heart Problems**	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	**Rheumatic Fever**	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	**Low Blood Pressure**	❑ Yes	❑ No
Stroke	❑ Yes	❑ No	**Artificial Prosthesis (i.e. Heart Valve or Joints)**	❑ Yes	❑ No
Anemia or Blood Disorder	❑ Yes	❑ No	**Prolonged Bleeding Due To Slight Cut**	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No	**Asthma**	❑ Yes	❑ No
Breathing or Sleep Problems (i.e. Snoring, Sinus)	❑ Yes	❑ No	**Thyroid or Parathyroid Disease**	❑ Yes	❑ No
Hormone Deficiency	❑ Yes	❑ No	**Diabetes**	❑ Yes	❑ No
Digestive Disorders (i.e. gastric re?ux)	❑ Yes	❑ No	**Shingles**	❑ Yes	❑ No
Osteoporosis/osteopenia (i.e. taking bisphosphonates)	❑ Yes	❑ No	**Arthritis**	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	**Contact Lenses**	❑ Yes	❑ No
Epilepsy, Convulsions (seizures)	❑ Yes	❑ No	**Neurologic Problems**	❑ Yes	❑ No
Viral Infections and Cold Sores	❑ Yes	❑ No	**Any lumps or swelling in the mouth**	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No	**HIV / AIDS**	❑ Yes	❑ No
Tumor, Abnormal Growth	❑ Yes	❑ No	**Radiation Therapy**	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	**Emotional Problems**	❑ Yes	❑ No
Psychiatric Treatment	❑ Yes	❑ No	**Antidepressant Medication**	❑ Yes	❑ No
Alcohol / Drug Dependency	❑ Yes	❑ No	**Alzheimer's Disease / Dementia**	❑ Yes	❑ No

If you have been hospitalized, please specify:

Are you:					
Presently being treated for any other illness	❑ Yes	❑ No	**Aware of any change in your general health**	❑ Yes	❑ No
Taking medication for weight management (i.e. fen-phen)	❑ Yes	❑ No	**Taking dietary supplement**	❑ Yes	❑ No
Often exhausted or fatigued	❑ Yes	❑ No	**Subject to frequent headaches**	❑ Yes	❑ No
A Smoker or smoked previously	❑ Yes	❑ No	**Taking recreational drugs**	❑ Yes	❑ No
FEMALE - Taking birth control pills	❑ Yes	❑ No	**FEMALE - Pregnant**	❑ Yes	❑ No
MALE - Prostate disorders	❑ Yes	❑ No			

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient Signature:

I agree that the above field represents my signature. ❑

Date:	**Doctor's Signature:**

Date: