# Medical History Info for NEW Adult Patient

**Patient Name** _____

**General health:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor  Date of last physical exam: _____

**Antibiotics:** Have you been told that you need to take antibiotics before dental treatment? Y N Reason _____

Before some dental treatments, patients who have certain heart conditions and those with artificial joints take antibiotics. These people may be at risk of developing an infection in the heart or at the site of the artificial joint, respectively. Antibiotics reduce this risk. If you are not sure, we can ask your M.D.

**Medical conditions**: Do you history of, or conditions related to, any of the following? *(Check all that apply)*

***General conditions***

| | |
|---|---|
| Alzheimer | Y N |
| Arthritis | Y N |
| Cancer: (TYPE _____) | Y N |
| Diabetes TYPE I OR II | Y N |
| Epilepsy/Seizures | Y N |
| Kidney/bladder disease | Y N |
| Liver disease or Jaundice | Y N |
| Osteoporosis | Y N |
| Stomach problems/ulcers | Y N |
| Stroke (DATE_____) | Y N |
| Thyroid/adrenal disease | Y N |

***Heart or Lung***

| | |
|---|---|
| Asthma | Y N |
| Emphysema | Y N |
| Heart disease | Y N |
| Heart murmur | Y N |
| HIGH / LOW blood pressure | Y N |
| Mitral valve prolapse | Y N |
| Rheumatic fever | Y N |
| Tuberculosis | Y N |

***Head***

| | |
|---|---|
| Ear aches or ringing | Y N |
| Glaucoma or eye disease | Y N |
| Hay fever or allergies | Y N |
| Head/Brain injury | Y N |
| Headaches/migraines | Y N |
| Sinus problems | Y N |

***Hematological (Blood-related)***

| | |
|---|---|
| Anemia | Y N |
| Bleeding (prolonged) | Y N |
| Hemophilia | Y N |

***Psychological/Emotional***

| | |
|---|---|
| Anxiety | Y N |
| Depression | Y N |
| Mental health disorder | Y N |
| Other _____ | Y N |

**Women**

| | |
|---|---|
| Pregnant: DUE DATE _____ | Y N |
| Nursing | Y N |
| Taking birth control pills? | Y N |
| Hormone replacement therapy | Y N |

***Infectious***

| | |
|---|---|
| Hepatitis (TYPE _____) | Y N |
| HIV infection (AIDS) | Y N |
| Herpes (mouth) | Y N |

***Substance use/Abuse***

| | |
|---|---|
| Drug use | Y N |
| Tobacco/Cigarette use | Y N |
| Alcohol Abuse | Y N |

***Other Conditions***

| | |
|---|---|
| Back pain | Y N |
| Bruise easily | Y N |
| Cough-persistent or bloody | Y N |
| Difficulty or excessive urination | Y N |
| Dry mouth or excessive thirst | Y N |
| Fainting or Dizziness | Y N |
| Frequent vomiting/nausea | Y N |
| Shortness of breath | Y N |
| Skin disease/rash | Y N |
| Sleep apnea/problems | Y N |
| Swollen ankles | Y N |
| Weight loss (significant) | Y N |

Other: _____ ____

***If any boxes checked, please describe further***:_____

**Medications**:

Are you taking any medications? Y N

*Please list medication, dose & reason:*

_____

_____

_____

_____

_____

_____

_____

*Have you ever used bisphosphonates (drugs used to treat osteoporosis)* Y N dates_____

**Treatment:**

Have you ever had any of the following treatments?

*If yes, indicate DATES*

| | | |
|---|---|---|
| Artificial Heart Valves | Y N | _____ |
| Blood transfusion | Y N | _____ |
| Chemotherapy/Radiation | Y N | _____ |
| Contact lenses | Y N | _____ |
| Cortisone/steroid | Y N | _____ |
| Joint Replacement | Y N | _____ |
| SPECIFY _____ | | |
| Pacemaker | Y N | _____ |
| Transplants | Y N | _____ |
| SPECIFY _____ | | |

**Allergies:**

*Are you allergic to any of the following?*

***Medications or drugs***

| | | | |
|---|---|---|---|
| Aspirin | Y N | Erythromycin | Y N |
| Codeine | Y N | Penicillin | Y N |
| Demerol | Y N | Sulfa | Y N |
| Darvon | Y N | Tetracycline | Y N |
| Percodan | Y N | Valium | Y N |
| Iodine | Y N | Vicodin | Y N |

***Latex/Rubber*** Y N

***Local Anesthetics*** Y N

***Jewelry/Metals*** Y N

***Other*** _____ Y N

**I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and is my responsibility to inform this office of any changes to my medical status.**

**X**_____ _____

*Patient's Signature* *Date*

_____ _____

*Dentist Review* *Date*

## RE-EVALUATION OF ORIGINAL MEDICAL HISTORY

At every visit, you will be asked to update your medical history. A complete medical history is essential and important for the safe and effective treatment. This form is completely confidential, and will be used only for dental and medical reasons.

| Date | Changes? | If yes, what changes? Include any serious illness, surgery or hospitalizations | Signature | Reviewed by |
|---|---|---|---|---|
| | Y N | | | |
| | Y N | | | |
| | Y N | | | |
| | Y N | | | |
| | Y N | | | |
| | Y N | | | |
| | Y N | | | |