PATIENT NAME____ DATE OF BIRTH__________________________
First Middle Last

Home address____

Home Phone____________________________ Mobile________________________ Office________________________

Adult Health History

Are you allergic to anything?..................Yes No

If YES-please specify:

- □ Penicillin
- □ Aspirin
- □ Codeine
- □ Novacaine
- □ Mycin Drugs
- □ Xylocaine
- □ Sulfa
- □ Latex
- □ Other__________________________

Do you have/had any of the following?

- Abnormal Bleeding/Hemophilia.............Yes No
- Acid Reflux/GERD.................................Yes No
- Aids/HIV Infection................................. Yes No
- Anemia/Sickle Cell Anemia................... Yes No
- Arthritis... Yes No
- Asthma.. Yes No
- Autoimmune Disorder.......................... Yes No
- Cancer..Yes No
- Cardiovascular Disease......................... Yes No

If YES-please specify:

- □Angina
- □Heart Attack
- □Arteriosclerosis
- □Heart Murmur
- □Artificial Heart Valve
- □High Blood Pressure
- □Congenital Heart Defect
- □Low Blood Pressure
- □Congestive Heart Failure
- □Mitral Valve Prolapse
- □Coronary Artery Disease
- □Pacemaker
- □Damaged Heart Valve
- □Rheumatic Fever
- □Other____________________________

- Cold Sores/Fever Blisters.................... Yes No
- Diabetes... Yes No
- Dizziness/Fainting.............................. Yes No
- Eating Disorder.................................. Yes No
- Epilepsy/Seizures............................... Yes No
- Frequent Headaches......................... Yes No
- Hepatitis/Liver Problems.................... Yes No
- Joint Replacement............................. Yes No
- Kidney Problems................................ Yes No
- Mental/Emotional Disorder............... Yes No
- Neurological Problems...................... Yes No
- Organ Transplant............................... Yes No
- Osteoporosis...................................... Yes No
- Radiation Treatment/Chemotherapy. Yes No
- Respiratory Disease/COPD................. Yes No
- Stroke.. Yes No
- Thyroid Problems............................... Yes No
- Tuberculosis....................................... Yes No

Are you taking prescription medications?........... Yes No

If YES-please list____________________________

____

____

Are you taking over-the-counter medications?.... Yes No

If YES-please list__________________________________

____

Are you taking any herbal supplements?............. Yes No

If YES-please list__________________________________

____

Are you pregnant?.. Yes No

If YES-what month?_______________________________

Have you had ANY surgeries?................................ Yes No

If YES, please specify:_____________________________

____

____

When was your last physical examination?_____________

Are you now under care of a physician?............... Yes No

If YES, why?_____________________________________

Do you currently use tobacco of any type?........... Yes No

If YES, which type?_______________________________

If YES, how long have you used tobacco____________

Are you a former tobacco user?............................ Yes No

If YES, which type?_______________________________

If YES, how long have you used tobacco?___________

- History of alcohol or drug dependency?................ Yes No
- Do you have any dry mouth issues?.........................Yes No
- Have you ever had any jaw problems?.....................Yes No
- Does your jaw ever pop or click?............................. Yes No
- Do you have pain or tenderness in jaw?.................. Yes No
- Has your jaw ever locked open or closed............... Yes No
- Do you clench or grind your teeth?......................... Yes No
- Have you had trauma to your chin or jaw?.............. Yes No
- History of periodontal disease?................................ Yes No
- If YES, have you had treatment?.............................. Yes No

Date of last dental care____________________

How do you feel about the appearance of your teeth? ____

____

Please circle below if you have had problems with any of the following:

*Bad Breath
*Sensitivity to cold
*Sensitivity to biting
*Bleeding Gums
*Sensitivity to hot
*Sores in mouth
*Food collection between teeth
*Sensitivity to sweets
*Loose teeth/Broken fillings

The above information is true and accurate to the best of my knowledge.

Signature____ **Date**____