



**Adult History**

Patient Name \_\_\_\_\_

What is your chief concern for us at this visit? \_\_\_\_\_

**\*\*Please circle Y (yes) or N (no) for the following questions, whichever applies. Your answers are for our records only and will be considered confidential. Please use the space after the question for additional explanations.**

**Medical History**

- Y N Are you in excellent health?
- Y N Has there been any change in your general health within the last year?
- Y N My last physical exam was \_\_\_\_\_(month/year)
- Y N Are you now under the care of a physician? If so, what is being treated? \_\_\_\_\_
- Y N Have you had a serious illness/hospitalization in the past 5 years?  
If so, for what? \_\_\_\_\_
- Y N Are you taking any medication (incl. non-prescription)? \_\_\_\_\_

Do you have any of the following conditions?

Allergies or drug reactions to:

- |   |   |
|---|---|
| Y N Latex   | Y N Abnormal bleeding or blood transfusion  |
| Y N Penicillin or other antibiotics   | Y N Low blood pressure  |
| Y N Sulfa drugs   | Y N Cardiovascular disease (heart trouble, attack, angina, high blood pressure, arteriosclerosis, stroke) |
| Y N Aspirin, Ibuprofen, Tylenol   | Y N Damaged or artificial heart valves, including heart murmur or rheumatic heart disease                 |
| Y N Local anesthetics   | Y N Arthritis or joint problems or artificial joints/limbs  |
| Y N Codeine or other narcotics  | Y N Require pre-medication before dental visits?  |
| Y N Other _____   | Y N Birth Defects   |
| Y N Respiratory problems, emphysema   | Y N Kidney trouble  |
| Y N Asthma or hay fever   | Y N Tuberculosis  |
| Y N Sinus trouble   | Y N Bone fractures or trauma to face or jaw   |
| Y N Persistent swollen neck glands  | Y N Vision, hearing or speech difficulty  |
| Y N Thyroid or endocrine problems   | Y N Persistent Cough  |
| Y N Diabetes  | Y N Frequent colds or sore throats  |
| Y N Hepatitis, jaundice or liver disease  | Y N Frequent headaches  |
| Y N AIDS or HIV infection   | Y N Stomach ulcer or hyperacidity   |
| Y N Sexually transmitted disease  | Y N Tumor (Cancerous or benign)   |
| Y N Substance abuse problem (past or present)   | Y N Radiation therapy or Chemotherapy   |
| Y N Mental health problem or nervous disorder   | Y N <b>Females:</b> Are you pregnant?   |
| Y N Fainting spells or seizures   |   |
| Y N Epilepsy or other neurological disease  |   |
| Y N Fainting spells or seizures   |   |
| Y N Blood disorder such as anemia   |   |
| Y N Do you have any disease, condition or problem not listed above that you think we should know about? |   |

If so, please explain \_\_\_\_\_