



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 Females: 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 _____