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 Penicillin or other antibiotics
Y N Sulfa drugs
Y N Aspirin, Ibuprofen, Tylenol
Y N Local anesthetics
Y N Codeine or other narcotics
Y N Other_____
Y N Respiratory problems, emphysema
Y N Asthma or hay fever
Y N Sinus trouble
Y N Persistent swollen neck glands
Y N Thyroid or endocrine problems
Y N Diabetes
Y N Hepatitis, jaundice or liver disease
Y N AIDS or HIV infection
Y N Sexually transmitted disease
Y N Substance abuse problem (past or present)
Y N Mental health problem or nervous disorder
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 Abnormal bleeding or blood transfusion
Y N Low blood pressure
Y N Cardiovascular disease (heart trouble, attack, angina, high blood pressure, arteriosclerosis, stroke)
Y N Damaged or artificial heart valves, including heart murmur or rheumatic heart disease
Y N Arthritis or joint problems or artificial joints/limbs
Y N Require pre-medication before dental visits?
Y N Birth Defects
Y N Kidney trouble
Y N Tuberculosis
Y N Bone fractures or trauma to face or jaw
Y N Vision, hearing or speech difficulty
Y N Persistent Cough
Y N Frequent colds or sore throats
Y N Frequent headaches
Y N Stomach ulcer or hyperacidity
Y N Tumor (Cancerous or benign)
Y N Radiation therapy or Chemotherapy
Y N **Females**: Are you pregnant?

Y N Do you have any disease, condition or problem not listed above that you think we should know about?

If so, please explain_____