ALLIANCE FOR DENTAL CARE

ALL THE SERVICES – ALL THE CARE

ADULT MEDICAL HISTORY

PATIENT'S NAME _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER

				COMMENTS
1.	Physician's Name _____ Address _____ _____			
2.	Are you under a physician's care?	YES	NO	
	Since when _____ Why? _____			
3.	When was your last complete physical exam? _____			
4.	Are you taking any medication?	YES	NO	
5.	Do you routinely take health related substances?	YES	NO	
6.	Are you allergic to any medications or substances?	YES	NO	
7.	Do you have any other allergies?	YES	NO	
8.	Do you have any problems with penicillin, antibiotics, anesthetics, or any other medications?.....	YES	NO	
9.	Are you sensitive to any metals or latex?	YES	NO	
10.	Are you pregnant or suspect that you may be?	YES	NO	
11.	Do you use any birth control medications?	YES	NO	
12.	Have you ever been treated for or been told you might have a heart disease?	YES	NO	
13.	Do you have a pacemaker or an artificial heart valve implant?	YES	NO	
14.	Have you ever had rheumatic fever?	YES	NO	
15.	Are you aware of any heart murmurs?	YES	NO	
16.	Do you have high or low blood pressure?	YES	NO	
17.	Have you ever had a serious illness or major surgery?	YES	NO	
	If so, explain _____			
18.	Have you ever had radiation treatment, chemo treatment for a tumor, growth, or other condition?	YES	NO	
19.	Do you have inflammatory diseases, such as arthritis or rheumatism?	YES	NO	
20.	Do you have any artificial joints/prosthesis?	YES	NO	
21.	Do you have any blood disorders, such as anemia, leukemia, etc?	YES	NO	
22.	Have you ever bled excessively after being cut or injured?	YES	NO	
23.	Do you have any stomach problems?			
24.	Do you have any kidney problems?	YES	NO	
25.	Do you have any liver problems?	YES	NO	
26.	Are you diabetic?	YES	NO	
27.	Do you have asthma?	YES	NO	
28.	Do you have epilepsy or seizure disorders?	YES	NO	
29.	Do you or have you had venereal disease?	YES	NO	
30.	Have you tested HIV positive?	YES	NO	
31.	Do you have AIDS?	YES	NO	
32.	Have you had or do you test positive for hepatitis?.....	YES	NO	
33.	Do you or have you had T.B.?	YES	NO	
34.	Do you smoke, chew, use snuff, or any other forms of tobacco?	YES	NO	
35.	Do you consume alcoholic beverages?	YES	NO	
36.	Do you habitually use controlled substances?	YES	NO	
37.	Have you had psychiatric treatment?	YES	NO	
38.	Do you have any disease, condition, or problem not listed? If so, explain	YES	NO	
	_____			
39.	Is there anything else we should know about your health that we have not covered in this form? _____	YES	NO	
40.	Would you like to speak to the Doctor privately about any problem?	YES	NO	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ Date _____

DENTIST'S SIGNATURE _____ Date _____