Adult Medical History **Account #_____**

Name _____ S.S. #:_____
Date of Birth:_____ Sex: F M Height:_____ Weight:_____
Race: _____ Ethnicity:_____Language Preference:_____
General Health: [ ] Excellent [ ] Good [ ] Fair
Name of Physician _____ Date of Last Physical _____

Are you taking any Aspirin daily? [ ] Y [ ] N
Are you taking Coumadin, Plavix or any other blood thinner? [ ] Y [ ] N
Have you taken any steroids or cortisone in the past year? [ ] Y [ ] N
Are you taking any other medications? [ ] Y [ ] N
List medications: _____

Please Check ALL that apply:

[ ] **Abnormal blood pressure _____/_____**
[ ] Anemia/blood disorders
[ ] Arthritis
[ ] Asthma
[ ] Blood Transfusion
[ ] Cancer
[ ] Diabetes
[ ] Epilepsy
[ ] Fainting Spells
[ ] Glaucoma
[ ] Heart Condition
[ ] Heart Surgery
[ ] Hepatitis
[ ] HIV
[ ] Hospitalizations SURGERY OR OVERNIGHT
[ ] Prescription diet pills
[ ] Prolonged Bleeding
[ ] Prosthetic Joint Replacement
[ ] Rheumatic Fever
[ ] Sexually Transmitted Disease
[ ] Sinus Trouble
[ ] Stroke
[ ] Tuberculosis/Lung Disease
[ ] Ulcers
[ ] Other _____

Allergies: [ ] Codeine [ ] Jewelry/Metal [ ] Latex [ ] Novocaine [ ] Penicillin
[ ] Other _____

Women: Are you pregnant [ ] Y [ ] N If Yes # of weeks:_____
Name of OB/GYN: _____

DENTAL HEALTH:
Date of last Dental Exam _____Date of last Dental Cleaning _____
How often do you brush? _____ Do your gums bleed when you brush? [ ] Y [ ] N
How often do you floss? _____**Do you smoke? [ ] Y [ ] N if yes, how much** _____
What kind of toothbrush do you use? [ ] Soft [ ] Medium [ ] Hard

Please Check all that apply:

[ ] Bleeding/tender gums
[ ] Clench/Grind teeth
[ ] Gag easily
[ ] Jaw/TMJ pain
[ ] Sensitive teeth (hot/cold/sweets)
[ ] Wear Dentures
[ ] Wear Partials
[ ] Wear Nightguard
[ ] Other_____

EXAMINATION AND X-RAYS I understand that the examination visits may require radiographs and diagnostic photos in order to complete the examination, diagnosis, and treatment plan.

Signature: _____ Date: _____