Brenden & Brenden

ADULT MEDICAL HISTORY

Name:____
Last First Middle

Date: ________________ Date of Birth: ________________

Who referred you to us? ____

PLEASE CIRCLE YOUR RESPONSES (*YES, NO*) TO INDICATE IF YOU HAVE, HAVE NOT OR DO NOT KNOW IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS.

GENERAL MEDICAL INFORMATION:

YES NO Are you currently under the care of a physician?____________________
If yes, what is the condition being treated?____________________

YES NO Have you had heart surgery? If yes, please specify: **STENTS VALVES BYPASS (CABG)** Other: ____________
Date(s) and any complications:____________________

YES NO Have you had an organ/bone marrow transplant? Specify: **HEART LUNG KIDNEY LIVER BMT** Other: ________
Date(s) and any complications:____________________

YES NO Have you had an orthopedic total joint replacement? If yes, please specify: **HIP KNEE OTHER**:____________
Date(s) and any complications:____________________

YES NO Do you now or have you ever had cancer? If yes, how was it treated?

- ☐ Surgery: diagnosis, site, when:____________________
- ☐ Radiation: diagnosis, site, when:____________________
- ☐ Chemotherapy: diagnosis, site, when:____________________

YES NO Have you taken Osteoporosis meds? (Fosamax, Boniva, Zometa, Actonel)

YES NO Have you had any serious illness, surgery, or been hospitalized? Within the past five years? Please explain:

____

____

Patient Medical Information **Please check yes or no**

Check, if within last 10 years			
☐ Y ☐ N No Known Concerns or Issues	☐ Y ☐ N Cardiac Pacemaker	☐ Y ☐ N Gall Bladder Trouble	☐ Y ☐ N Premedication Required
☐ Y ☐ N AIDS/HIV Infection	☐ Y ☐ N Chemotherapy	☐ Y ☐ N Heart Attack / Stroke	☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Alcohol/Drug Abuse	☐ Y ☐ N Chest Pain Upon Exertion	☐ Y ☐ N Heart Disease / Angina	☐ Y ☐ N Rheumatic Heart Disease
☐ Y ☐ N Anemia	☐ Y ☐ N Color Blindness	☐ Y ☐ N Heart Murmur	☐ Y ☐ N Seasonal Allergies
☐ Y ☐ N Ankles Swell	☐ Y ☐ N Contact Lenses	☐ Y ☐ N Hepatitis	☐ Y ☐ N Sexually Transmitted Disease
☐ Y ☐ N Anorexia	☐ Y ☐ N Damaged Heart Valve	☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Shortness of Breath
☐ Y ☐ N Arthritis	☐ Y ☐ N Deaf	☐ Y ☐ N Hives / Skin Rash	☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Asthma / Hay Fever	☐ Y ☐ N Depression / Anxiety	☐ Y ☐ N Jaundice	☐ Y ☐ N Smoking/Tabacco Use
☐ Y ☐ N Blood Clotting Problems	☐ Y ☐ N Diabetes	☐ Y ☐ N Joint Replacement	☐ Y ☐ N Stomach Ulcers
☐ Y ☐ N BLOOD THINNERS	☐ Y ☐ N Emphysema	☐ Y ☐ N Kidney / Bladder Trouble	☐ Y ☐ N Thyroid Problems
☐ Y ☐ N Blood Transfusion	☐ Y ☐ N Epilepsy	☐ Y ☐ N Liver DiseaseProblems	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Bronchitis	☐ Y ☐ N Fainting Spells / Seizures	☐ Y ☐ N Low Blood Pressure	☐ Y ☐ N Unusual Weight Loss
☐ Y ☐ N Bulimia	☐ Y ☐ N Fever Blisters / Cold Sores	☐ Y ☐ N Mental Health	☐ Y ☐ N Urinate Frequently
☐ Y ☐ N Cancer / Tumor or Growth	☐ Y ☐ N Frequent Headaches	☐ Y ☐ N Mitral Valve Prolapse	**OTHER**
	☐ Y ☐ N Frequently Dry Mouth / Sjogren	☐ Y ☐ N Persistent Diarrhea	☐ Y ☐ N List of CURRENT Medications

(over)

FEMALES ONLY:

YES NO Are you or could you be pregnant? If yes, number of weeks _________ and due date: _________________

YES NO Are you nursing?

ALLERGIES TO DRUGS OR LATEX:

YES NO DK Are you allergic to or have you had a reaction to any of the following? Please specify type of reaction:

- ☐ Local anesthetics (Lidocaine/Epinephrine)
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Other antibiotics (Specify): ____________________
- ☐ Aspirin
- ☐ Advil (Ibuprofen)
- ☐ Tylenol (Acetaminophen)
- ☐ Codeine
- ☐ Opioids (hydrocodone, oxycodone)
- ☐ Chlorhexidine mouth rinse (Peridex/Periguard)
- ☐ Metals/Jewelry (nickel/chrome)
- ☐ Other Medication(s) (Specify): _________________
- ☐ Dietary allergies
- ☐ Latex (rubber)

Reaction(s) to above: ____

MEDICATIONS:

YES NO DK Are you taking, or are you supposed to be taking any medications - prescription, over the counter, dietary supplements, herbal medicine or vitamins? If yes, please list below.

Medications or Supplements: Prescription, over the counter, dietary supplement, herbal medicines and vitamins	**Dose** (mg)	**How Often:** (once a day, twice a day, etc.)	**Date Started:**	**Reason for Use:**

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of patient (or parent/guardian if minor)