Dakota Family Dentistry
Adult Medical History Form

Patient's Name_____
Last First Initial Date of Birth

Physician Name:	Physician Phone #:
Physician Address:	
Pharmacy:	Pharmacy Phone#:

Medications (List all medications you take):

Allergies:

_____Penicillin _____Latex/Metals _____Dental Anesthetics _____Aspirin _____Codeine _____Sulfa

Other_____

MEDICAL HISTORY- Circle the Appropriate Answer

1. Are you under a physician's care?----------YES NO
   Since when_____ Why_____
2. When was your last physical?_____
3. Do you routinely take health related substances? (vitamins, herbal supplements, natural products)---------YES NO
4. Are you pregnant or suspect you may be?----------Yes NO
   If yes, # of weeks_____
5. Are you nursing?----------YES NO
6. Are you on birth control?----------YES NO
7. Have you ever been treated for or been told you might have heart disease?----------YES NO
8. Do you have a pacemaker or an artificial heart valve implant?----------YES NO
9. Have you ever had rheumatic fever?----------YES NO
10. Are you aware of any heart murmurs?----------YES NO
11. Do you have high or low blood pressure? (circle high or low)----------YES NO
12. Have you ever had a serious illness or major surgery?----------YES NO
    If yes, explain_____
13. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?----------YES NO
    If yes, explain_____
14. Do you have inflammatory diseases, such as arthritis or rheumatism?----------YES NO
15. Do you have osteoporosis?----------YES NO
16. Have you ever taken a bisphosphonates? (Fosamax, Boniva, Etc.)----------YES NO
    If yes, what_____ How long_____
17. Do you have any artificial joints/prosthesis?----------YES NO
    If yes, explain_____
18. Do you have any blood disorders, such as anemia, leukemia, etc?----------YES NO
19. Have you ever bled excessively after being cut or injured?----------YES NO
20. Do you have any stomach problems?----------YES NO
21. Do you have any kidney problems?----------YES NO
22. Do you have any liver problems?----------YES NO
23. Are you diabetic?----------YES NO

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MEDICAL HISTORY CONTINUED - Circle the Appropriate Answer

24. Do you have fainting or dizzy spells?----------YES NO
25. Do you have asthma?----------YES NO
26. Do you have epilepsy or seizure disorders?----------YES NO
27. Do you or have you had venereal disease?----------YES NO
28. Have you tested HIV positive?----------YES NO
29. Do you have AIDS?----------YES NO
30. Have you had or do you test positive for hepatitis?----------YES NO
31. Do you or have you had T.B.?----------YES NO
32. Do you smoke, chew, use snuff or any other forms of tobacco?----------YES NO
33. Do you regularly consume more than one or two alcoholic beverages a day?----------YES NO
34. Do you habitually use controlled substances?----------YES NO
35. Have you had psychiatric treatment?----------YES NO
36. Have you taken any weight reduction medications? (Fen-Phen, Redux, etc.)----------YES NO
37. Do you have any disease condition, or problem not listed----------YES NO
    If so, explain_____
    _____
38. Is there anything else we should know about your health that we have not covered in this form?----------YES NO
    If so, explain_____
    _____
49. Would you like to speak to the Doctor privately about any problem?----------YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATENT'S / GUARDIAN'S SIGNATURE_____DATE_____