Adult Medical History

DOB: ___________________________

Patient Name: ____ Preferred Name: ____________________

Address & Phone #:____

Cell phone #: _________________________ Employer: _____________________________________ Work #: _________________________

Person to contact in case of an emergency and their phone #: ____

Do you have any of the following diseases or medical problems?

- ❑ Active Tuberculosis
- ❑ Been exposed to anyone with tuberculosis
- ☐ Persistent cough greater than a 3-week duration
- ☐ Cough that produces blood

If you marked any of the above items, please stop and return this form to the receptionist.

Name of personal physician: ____ Approximate date of last visit: ______________

Address & phone #: ____

Have you had any serious illness, operation or been hospitalized in the last five years? ☐ No ☐ Yes If yes, please explain:
____

Are you currently pregnant? ☐ No ☐ Yes If yes, how many months? ___________________________________

Are you taking any medications? ☐ No ☐ Yes Please list below medications, vitamins and/or herbal supplements you currently take:

Name of Medication: *Reason:*
____
____

Are you taking, or have you taken in the past, any drugs for bone density, osteoporosis or osteopenia? ☐ No ☐ Yes If yes, please give the date you started: _______________; the date you stopped: __________________; the name of the medication: __________________________.

Please check if you are allergic to any of the following:

- ☐ Local anesthetics
- ☐ Penicillin/other antibiotics
- ☐ Barbiturates, sedatives, sleeping pills
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Other
- ☐ Codeine/other narcotics
- ☐ Latex sensitivity

The following conditions **may require** a pre-medication with antibiotics. Please check if any of them apply to you (or have in the past).

- ☐ Heart murmur
- ☐ Prosthetic implant:
  Joint & date: ____________________
- ☐ Artificial (prosthetic) heart valve
- ☐ Congenital heart disease (CHD)
  - ☐ Unrepaired, cyanotic CHD
  - ☐ Repaired (completely) in last 6 months
  - ☐ Repaired CHD with residual defects
- ☐ Mitral valve prolapse
- ☐ Surgery with pins
  Area & date: _____________
- ☐ Previous infective endocartitis
- ☐ Rheumatic fever
- ☐ You are undergoing treatment for cancer
- ☐ Transplant surgery
  Organ & date: _________________
- ☐ Damaged valves in transplanted heart
- ☐ You have taken the diet drug Fen Phen:
  date: _____________

Please indicate if you have ever had or been treated for any of the following diseases or medical problems:

- ☐ Abnormal bleeding
- ☐ Abnormal blood pressure
- ☐ HIV+
- ☐ Arthritis
- ☐ Cancer
- ☐ Depression
- ☐ Glaucoma
- ☐ Heart attack/Stroke
- ☐ Hepatitis A / B / C
- ☐ Nervous disorder
- ☐ Tumor
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ AIDS/ARC
- ☐ Ulcers
- ☐ Radiation therapy
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Heart disease
- ☐ Psychiatric condition/Depression
- ☐ Bruise easily
- ☐ Venereal disease
- ☐ Emphysema
- ☐ Blood relatives with diabetes
- ☐ Excessive urination
- ☐ Kidney trouble
- ☐ Fainting spells
- ☐ Epilepsy/Seizures
- ☐ Dental implant
- ☐ Hay fever/ Asthma
- ☐ Pacemaker
- ☐ Jaundice
- ☐ Drug/Alcohol abuse

_______ I have been made aware of the privacy policies of Henniker Family Dentistry (please initial).

*Patient's Signature*____ *Date:*____________________