Adel
DENTAL GROUP

Adult Medical History

Patient Name:_____

Welcome to Anderson Dental Group! We're excited to provide you with the best possible care!
Please know that all medical history provided will be kept completely confidential.

What is the reason for your visit today?_____

Are you currently under a physician's care? ☐ Yes ☐ No _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No _____

Are you currently taking any medications, pills, or drugs? ☐ Yes ☐ No List all medications:_____

_____

Are you currently taking any blood thinners? ☐ Yes ☐ No _____

Do you currently take, or have you taken, Redux, Fosamax, Boniva, Acontel, or any medication containing bisphosphonates? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No _____

Do you use tobacco? ☐ Yes ☐ No _____

Are you **allergic** to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Peanuts	☐ Corn	☐ Dairy	☐ Soy

Other allergies not listed? ☐ Yes ☐ No _____

Do you have any allergic or adverse reactions to any medication or any other substance not listed above?

☐ Yes ☐ No _____

WOMEN: Are you – ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Indicate which of the conditions you currently have or have ever had:

☐ AIDS/HIV positive	☐ Cortisone Medicine	☐ Heart Trouble/Disease	☐ Renal Dialysis
☐ Alzheimer's Disease	☐ Diabetes	☐ Hemophilia	☐ Rheumatic Fever
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis A, B, or C	☐ Scarlet Fever
☐ Anemia	☐ Easily Winded	☐ Herpes (Cold Sores)	☐ Shingles
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Epilepsy/Seizures	☐ High Cholesterol	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Stomach/Intestinal Disease
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney/Liver Problems	☐ Stroke
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Low Blood Pressure	☐ Thyroid Problems
☐ Brain Injury/ Concussions	☐ Frequent Headaches	☐ Lung Disease	☐ Tonsillitis
	☐ Genital Herpes	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Breathing Problem	☐ Glaucoma	☐ Osteoporosis	☐ Tumors/Growths
☐ Bruise Easily	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Ulcers
☐ Cancer	☐ Hearing Problem	☐ Parathyroid Disease	☐ Venereal Disease
☐ Chemotherapy	☐ Heart Attack/Failure	☐ Psychiatric Care	☐ Yellow Jaundice
☐ Chest Pains	☐ Heart Murmur	☐ Radiation Treatments	☐ Other _____
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Recent Weight Loss	

Additional conditions or information we should know about you:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature:_____ Date:_____