Menta DENTISTRY

ADULT MEDICAL HISTORY
(Patient's 18 years of age and older)

Patient Name: _____ Patient D.O.B.: _____

I. CIRCLE THE APPROPRIATE ANSWER (leave blank if you do not understand the question):

1.	Is your general health good?	Yes	No
2.	Has there been a change in your health within the last year?	Yes	No
3.	Have you been hospitalized or had a serious illness in the last year?	Yes	No
	If yes, why? _____		
4.	Are you being treated by a physician now? For what?	Yes	No
	If yes, for what? _____ Name of Physician: _____		
5.	Have you had problems with prior dental treatment?	Yes	No
6.	Are you in any pain now?	Yes	No

II. HAVE YOU EXPERIENCED:

7.	Chest Pain (Angina)?	Yes	No	18. Dizziness?	Yes	No
8.	Swollen Ankles?	Yes	No	19. Ringing in ears?	Yes	No
9.	Shortness of breath?	Yes	No	20. Headaches?	Yes	No
10.	Recent weight loss, fever, night sweats?	Yes	No	21. Fainting spells?	Yes	No
11.	Persistent cough, coughing up blood?	Yes	No	22. Blurred vision?	Yes	No
12.	Bleeding problems, bruising easily?	Yes	No	23. Seizures?	Yes	No
13.	Sinus Problems?	Yes	No	24. Excessive thirst?	Yes	No
14.	Difficulty Swallowing?	Yes	No	25. Frequent urination?	Yes	No
15.	Diarrhea, constipation, blood in stools?	Yes	No	26. Dry mouth?	Yes	No
16.	Frequent vomiting?	Yes	No	27. Jaundice?	Yes	No
17.	Difficulty urinating, blood in urine?	Yes	No	28. Joint pain, stiffness?	Yes	No

III. DO YOU HAVE OR HAVE YOU HAD:

29. Heart disease?	Yes	No	40. AIDS?	Yes	No
30. Heart attack, Heart defects?	Yes	No	41. Tumors, Cancer?	Yes	No
31. Heart murmurs?	Yes	No	42. Arthritis, Rheumatism?	Yes	No
32. Rheumatic fever?	Yes	No	43. Eye disease?	Yes	No
33. Stroke, hardening of arteries?	Yes	No	44. Skin disease?	Yes	No
34. High blood pressure?	Yes	No	45. Anemia?	Yes	No
35. Asthma, TB, emphysema, lung disease?	Yes	No	46. Venereal disease?	Yes	No
36. Hepatitis, other liver disease?	Yes	No	47. Herpes?	Yes	No
37. Stomach problems, ulcers?	Yes	No	48. Kidney, bladder disease?	Yes	No
38. Allergies to: drugs, food, medication?	Yes	No	49. Thyroid, adrenal disease?	Yes	No
39. Diabetes?	Yes	No			
50. Family history of diabetes, heart problems, cancer, high blood pressure?				Yes	No

IV. DO YOU HAVE OR HAVE HAD:

51. Psychiatric care?	Yes	No	56. Hospitalization?	Yes	No
52. Radiation Treatment?	Yes	No	57. Blood Transfusion?	Yes	No
53. Chemotherapy?	Yes	No	58. Surgeries?	Yes	No
54. Prosthetic heart valve?	Yes	No	59. Pacemaker?	Yes	No
55. Artificial joint?	Yes	No	60. Contact Lenses?	Yes	No

V. ARE YOU TAKING?

61. Recreational Drugs?	Yes	No	63. Tobacco in any form?	Yes	No
62. Drugs, medications, over-the-counter meds?	Yes	No	64. Alcohol?	Yes	No

Please list the medication you are taking: _____

VI. WOMEN ONLY:

65. Are you or could you be pregnant or nursing?	Yes	No	66. Taking Birth Control?	Yes	No

VI. ALL PATIENTS:

67. Do you or have you had any other diseases or medical problems NOT listed on this form?	Yes	No

If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any changes in my health and/or medication.

Patient's Signature: _____ **Today's Date:** _____