Patient Name: _____

Patient DOB: _____

History Form - Adult

edinadentalcare
COMPREHENSIVE AND AESTHETIC DENTAL CARE

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely.

Have there been any changes in your general health in the past year, including pregnancy?If yes, please describe: ☐ Yes ☐ No

Please list your physician's name and clinic:

When were you last seen by your physician?

Are your currently under a physician's care for a particular problem? ☐ Yes ☐ No

If yes, please explain:

Have you been hospitalized or had a serious illness within the last 10 years? ☐ Yes ☐ No

If yes, please describe:

Do you, or have you ever had?

- ☐ Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary aretery disease, chest pain, high or low blood pressure, stroke, irregular heart beat, history of heart surgery, pacemaker)?
- ☐ Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, sever coughing)
- ☐ Bleeding disorder, anemia, bleeding tendency, history of blood transfusion
- ☐ Implants (heart valve, pacemaker, joint replacement)
- ☐ Kidney disease or kidney failure, requiring dialysis
- ☐ Liver disease (jaundice, hepatitis A, B, or C)
- ☐ Thyroid disease
- ☐ Cancer, or history of cancer
- ☐ Radiation or chemotherapy
- ☐ History of transplant operation
- ☐ Seizures, convulsions, epilespy, fainting or dizziness
- ☐ Osteoporosis or osteopenia
- ☐ Anxiety
- ☐ Depression
- ☐ Headaches
- ☐ Substance abuse
- ☐ Clicking, popping, or pain within the jaw joint and/or difficulty opening the mouth
- ☐ Snoring or sleep apnea
- ☐ Sinus or nasal problem
- ☐ Gastrophageal reflux disease (GERD)
- ☐ Stomach ulcers or colitis
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Veneral disease
- ☐ AIDS/HIV
- ☐ I do not, or have not had any of these listed conditions

Do you have any other disease, condition, or problem that we should be aware of? ☐ Yes ☐ No

If yes, please describe:

Do you have a history of smoking, chewing tobacco, or vaping? ☐ Yes ☐ No

If yes, when and for how long?

Have you every had any adverse effects from dental treatment? ☐ Yes ☐ No

If yes, please explain:

MEDICATIONS

Are you using any of the following?

- ☐ Antibiotics
- ☐ Heart drugs
- ☐ Aspirin such Motrin, Aleve, Ibuprofen
- ☐ Prescription pain medication
- ☐ Anti-anxiety agents, antidepressants, sedative hypnotics
- ☐ Steroids (cotisone, prednisone, etc)
- ☐ Insulin or oral anti-diabetic drugs
- ☐ Bisphosphonates, antiangeongenic, and/or antiresportive medications for osteoporosis, multiple myeloma, or other cancers?

If yes, please list medications, when they are used, and frequency:

_____

Are you currently taking any high blood pressure medications? ☐ Yes ☐ No

Are you using a blood thinner medication such as Coumadin? ☐ Yes ☐ No

If yes, what is your most recent INR number and what date was it taken?

_____

Are there any other medications that you are currently taken that are not listed above? ☐ Yes ☐ No

If yes, please list any other medications you are currently taking:

_____

_____

_____

Has it been recommend by your physician that you take an antibiotic prior to any dental treatment? ☐ Yes ☐ No

If yes, please explain:

_____

ALLERGIES

Are you allergic, or have you had an adverse reaction to any of the following?

- ☐ Aspirin, Motrin, Aleve, or Ibuprofen
- ☐ Codine or other pain medication
- ☐ Latex
- ☐ Penicillin or other antibiotics
- ☐ Other
- ☐ No allergies or allergic reactions to the listed medications

If other, please explain:

_____

Have you or an immediate family member had any problems associated with local anestheia? ☐ Yes ☐ No

If yes, please explain:

_____

Is there anything else Edina Dental Care should be aware of regarding your overall health?

_____

_____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Relationship to Patient: _____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge the above information is cormplete and correct.

Signature of patient or guardian: _____ Date: _____

Printed name of patient or guardian: _____

Signature of Doctor: _____ Date: _____

Clinical Initials: _____