



# Rye Family Dentistry Adult Medical History

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Emergency Contact (Name/Phone Number) \_\_\_\_\_

## Medical History

1. Physician \_\_\_\_\_ Address \_\_\_\_\_

2. When was your last physical examination? \_\_\_\_\_

3. Are you under the care of a physician?.....  Yes  No

If yes, for what reason(s)? \_\_\_\_\_

4. Are you presently taking any medications/drugs/pills/herbals/supplements?.....  Yes  No

If yes, please list: \_\_\_\_\_

5. (Women) Is there a chance you are pregnant? .....  Yes  No

If yes, anticipated due date? \_\_\_\_\_

6. Do you take oral contraceptives? .....  Yes  No

7. Are you allergic/sensitive to:  None  Codeine  Penicillin  Local Anesthetic  Latex  Pine Nuts  Dyes

Other \_\_\_\_\_

8. Do you smoke, chew or use E-cigarettes? .....  Yes  No

If yes, please indicate which one(s), daily frequency and how long? \_\_\_\_\_

9. Do you have Diabetes? .....  Yes  No

If Yes, please indicate .....  Type 1  Type 2 Last HbA1c date and level \_\_\_\_\_

10. Do you have, or have you ever had:

- Abnormal blood pressure .....  Yes  No
- Anemia.....  Yes  No
- Arthritis.....  Yes  No
- Artificial heart valve/stent/graft.....  Yes  No
- Artificial joint replacements.....  Yes  No
- Asthma.....  Yes  No
- Cancer.....  Yes  No
- Chemical dependency.....  Yes  No
- Chemotherapy/radiation.....  Yes  No
- Congenital heart defects.....  Yes  No
- Corticosteroid treatment.....  Yes  No
- Epilepsy/seizures.....  Yes  No
- Excessive or prolonged bleeding.....  Yes  No
- Fainting Spells .....  Yes  No
- Glaucoma.....  Yes  No
- Hearing impaired.....  Yes  No
- Heart murmur.....  Yes  No
- Heart pacemaker.....  Yes  No

- Heart surgery .....  Yes  No
- Heart trouble .....  Yes  No
- Hepatitis (Type) .....  Yes  No
- HIV positive/AIDS .....  Yes  No
- Jaundice .....  Yes  No
- Kidney trouble/Dialysis .....  Yes  No
- Leukemia .....  Yes  No
- Oral herpetic lesions .....  Yes  No
- Osteoporosis/treatment w/Bisphosphonates..  Yes  No
- Psychiatric care .....  Yes  No
- Rheumatic fever .....  Yes  No
- Sexually Transmitted disease .....  Yes  No
- Sinus Trouble .....  Yes  No
- Stroke .....  Yes  No
- Thyroid problem .....  Yes  No
- Tuberculosis or Lung Disease .....  Yes  No
- Ulcers/GERD .....  Yes  No
- Do you take pre-medication for anything? ...  Yes  No
- If you pre-medicate, what for? \_\_\_\_\_

11. Have you had any other serious illness, hospitalization or accident?  Yes  No

If yes, please explain: \_\_\_\_\_

(OVER PLEASE)



# Adult Medical History

## Dental History

1. Former Dentist \_\_\_\_\_ Address \_\_\_\_\_
2. When did you last visit a dentist? \_\_\_\_\_ When was your last cleaning? \_\_\_\_\_  
 X-rays taken? .....  Yes  No  
 If yes:  Full Mouth Series  Bitewings  Panoramic  
 What was done at your last visit? \_\_\_\_\_  
 Why did you leave that dentist? \_\_\_\_\_  
 Has any dental treatment been recommended to you that you have not had done? \_\_\_\_\_
3. Are you aware of any dental problems? .....  Yes  No  
 Explain: \_\_\_\_\_
4. Please rate the present condition of your mouth. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
5. Have you ever been treated for gum disease? .....  Yes  No  
 If yes, what was done? \_\_\_\_\_
6. Do you have well water? .....  Yes  No
7. Is your water fluoridated? .....  Yes  No
8. Are your teeth sensitive to:  Nothing  Sweet  Cold  Heat  Pressure
9. Please rate the appearance of your smile. **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
10. Would you like a whiter smile? .....  Yes  No
11. Would you like straighter teeth? .....  Yes  No
12. Have you had your teeth straightened/worn braces? .....  Yes  No
13. Are you concerned with bad breath (malodor)? .....  Yes  No
14. Are you concerned with snoring or sleep apnea? .....  Yes  No
15. Are you concerned with grinding or clenching your teeth (bruxism)? .....  Yes  No
16. Do you wear a bite guard? .....  Yes  No
17. Are you aware of possible TMJ problems - does your jaw joint make noise, lock up or create pain? .....  Yes  No
18. Are you interested in sleep/sedation dentistry? .....  Yes  No
19. Is there anything else that would be valuable for your dentist to know to best care for you? \_\_\_\_\_

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.
- I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent/Guardian)

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_