1666 Marine Parkway, Brooklyn, NY 11234
(718)-339-0252

Adult Medical History Form

Date_____ **Social Security**_____
Name_____ **Occupation**_____
Address_____ **Home Phone**_____
City_____ **Cell Phone**_____
State_____ **Name of Spouse**_____
Zip Code_____ **Spouse's phone**_____
Date Of Birth_____/_____/_____ **Closest Relative**_____
Sex_____ **Relative's phone**_____
Email:_____

If you're completing this form for another person, what's your relationship to the patient?

_____

Referred by_____

Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions concerning your health and your responses to this questionnaire. Please circle yes or no for each of the following questions

1. **Are you in good health?** **Yes** **No**
2. **Has there been any change in your general health within the past year?** **Yes** **No**
3. **My last physical examination was** _____
4. **Are you now under the care of a physician?** **Yes** **No**

If yes, what is the condition being treated?

_____

5. **The name and address of my physician(s) is**

   _____

6. **Have you had any serious illness, operation, or been hospitalized in the past 5 years?** **Yes No**

If yes, what was the illness or problem?_____

7. **Are you taking any medicine(s) including non-prescription medicine?** **Yes No**

If yes, what medicine(s) are you taking?

_____

_____

8. **Do you have or have any of the following diseases or health problems? (<u>Please circle yes or no and if one line has multiple conditions listed, please circle the one you have)</u>**

- **Damaged heart valves, heart murmur, or rheumatic heart disease** **Yes No**
- **Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)** **Yes No**
    - **Do you have chest pain upon exertion?** **Yes No**
    - **Are you ever short of breath after mild exercise or lying down?** **Yes No**
    - **Do your ankles swell?** **Yes No**
    - **Do you have any inborn heart defects?** **Yes No**
    - **Do you have a cardiac pacemaker?** **Yes No**
- **Seasonal Allergies** **Yes No**
- **Sinus Trouble** **Yes No**
- **Asthma or Hay Fever** **Yes No**
- **Fainting spells or seizures** **Yes No**
- **Persistent diarrhea or recent weight loss** **Yes No**
- **Diabetes** **Yes No**
- **Hepatitis, jaundice or liver disease** **Yes No**
- **AIDS or HIV infection** **Yes No**
- **Thyroid Problems** **Yes No**
- **Respiratory problems, sleep apnea, emphysema, or bronchitis** **Yes No**

- **Arthritis or painful swollen joints** **Yes No**
- **Stomach ulcer or hyperacidity** **Yes No**
- **Kidney Trouble** **Yes No**
- **Tuberculosis** **Yes No**
- **Persistent cough or cough that produces blood** **Yes No**
- **Persistent swollen glands in neck** **Yes No**
- **Low Blood Pressure** **Yes No**
- **Sexually Transmitted Disease** **Yes No**
- **Epilepsy or other neurological disease** **Yes No**
- **Problems with mental health?** **Yes No**
- **Have you had any prosthetic joint replacements: If yes, what kind?** **Yes No**
  _____
- **Cancer: If yes, what kind? _____** **Yes No**
- **Problems with your immune system?** **Yes No**
- **Are you on any medications for Osteoporosis?** **Yes No**

9. **Have you had any abnormal bleeding?** **Yes No**
   - **Have you ever required a blood transfusion?** **Yes No**
10. **Do you have any blood disorders like anemia?** **Yes No**
11. **Have you ever had any treatment for a tumor?** **Yes No**
12. **Are you allergic or have you had any reaction to:**
    - **Local Anesthetics** **Yes No**
    - **Penicillin or other antibiotics** **Yes No**
    - **Sulfur Drugs** **Yes No**
    - **Barbiturates, sedatives, or sleeping pills** **Yes No**
    - **Aspirin** **Yes No**
    - **Iodine** **Yes No**
    - **Codeine or other narcotics** **Yes No**
    - **Other medication not listed here:_____** **Yes No**

13. **Have you ever had any serious trouble associated with previous dental treatment?** **Yes No**

If yes, please explain

_____

_____

14. **Do you have any disease, condition, or problem not listed above that you think I should know about?** **Yes No**

If yes, please explain

_____

_____

15. **Are you wearing contact lenses?** **Yes No**

16. **Are you wearing removable dental appliances?** **Yes No**

17. **Do you smoke?** **Yes No**

If yes, for how long and how much do you smoke? _____

18. **Do you have any prosthetics?** **Yes No**

WOMEN ONLY

1. **Are you pregnant?** **Yes No**
2. **Do you have any problems associated with your menstrual period?** **Yes No**
3. **Are you nursing?** **Yes No**
4. **Are you taking birth control pills?** **Yes No**

Dental Health

When was your last dental visit?_____

How often did you see your dentist?_____

Are you having any dental problems that require immediate attention?

_____

Do any of the following cause tooth discomfort (check those that apply):

Hot_____ Cold_____ Sweets_____Chewing_____

How often do you brush your teeth?_____ Floss_____ Water Jet_____

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Have you ever had periodontal treatment? If yes, when and for what

_____

Do you clench or grind your teeth? _____
Does your jaw ever feel tired or ache?_____ Click or pop?_____
Can you chew on both sides of your mouth? _____ Comfortably? _____
Do you have frequent headaches? _____ Earaches? _____

Have you ever had orthodontic treatment (braces)? If yes, when _____
Do you lose or break fillings? _____
Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken? _____
Do you have noticeable wear on your teeth? _____ Food traps? _____
Do you have any missing teeth? _____
Have they been replaced? _____ If yes, how was it replaced? (Check all that apply)
Fixed Bridge _____ Removable Partial _____ Full Denture ____ Implant _____
Are you comfortable with the replacement? _____
Please describe your replacement: _____

How do you feel about the appearance of your smile? _____
Have you ever had any cosmetic dentistry done to improve your appearance? If yes, describe what you have done _____
Are you pleased with your results from past cosmetic dentistry treatment? _____
Have you ever had an unpleasant dental experience? _____

Please add anything you feel is important to the bottom end of this page. Thank you!

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

***X*_____**

Signature of Patient