

Adult Medical /Dental History Form

TODAY'S DATE _____

PATIENT NAME _____ DATE OF BIRTH _____
First Last Initial dd/mm/yy

PHYSICIAN'S NAME _____ PHONE NUMBER _____

ADDRESS _____

CIRCLE THE APPROPRIATE ANSWER

MEDICAL HISTORY

1. Are you currently under a physician's care? Y N
If so, why? _____
2. When was your last complete physical exam? _____
3. Are you taking any medications or health related substances? Y N
If so, please list:
What? _____ Why? _____
What? _____ Why? _____
What? _____ Why? _____
What? _____ Why? _____
4. Are you allergic to any medications or substances? Y N
If so, what? _____
5. Do you have asthma or other respiratory difficulties? Y N
6. Have you ever had rheumatic fever? Y N
7. Are you aware of any heart murmurs? Y N
8. Do you have high blood pressure? Y N
9. Do you have a pacemaker or an artificial heart valve? Y N
10. Do you have any other heart disease or condition? Y N
11. Do you have any blood disorders such as anemia, leukemia, etc? Y N
12. Have you ever bled excessively after being cut or injured? Y N
13. Have you ever had a serious illness or major surgery? Y N
If so, explain _____
14. Have you ever had radiation treatment to you head or neck? Y N
15. Do you have arthritis or rheumatism? Y N
16. Do you have any artificial joints, implants or prosthesis? Y N
17. Do you have any stomach problems? Y N
18. Do you have any kidney problems? Y N
19. Do you have any liver problems? Y N
20. Are you a diabetic? Y N
21. Do you have epilepsy or seizure disorder? Y N
22. Do you have or have had venereal disease? Y N
If so, what and when? _____
23. Have you tested HIV positive? Y N
24. Do you have AIDS? Y N
25. Have you had or do you test positive for hepatitis? Y N
26. Do you or have you had TB? Y N
27. Do you smoke or use any other form of tobacco? Y N
If so, what and how much? _____

FOR OFFICE USE ONLY

DATE _____ BP _____
 DATE _____ BP _____
 DATE _____ BP _____
 DATE _____ BP _____
 DATE _____ BP _____

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