Adult Medical and Dental History

Today's Date _____

Patient Name _____ D.O.B_____ Soc. Sec. #_____

Emergency Contact (Name/Phone)_____

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. (Women) Do you take oral contraceptives?.....☐Yes ☐No
7. Are you allergic/sensitive to: ☐None ☐Codeine ☐Penicillin ☐Local Anesthetic ☐Latex ☐Nuts ☐Dyes ☐Other: _____
8. Do you smoke, chew tobacco, 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
Blood Disease/Bleeding Issues.....☐Yes ☐No
Chemical Dependency..... ☐Yes ☐No
Chemotherapy/Radiation..... ☐Yes ☐No
Congenital Heart Defects..... ☐Yes ☐No
Corticosteroid Treatment.....☐Yes ☐No
Epilepsy/Seizures/Fainting.....☐Yes ☐No
Excessive or prolonged bleeding.....☐Yes ☐No
Glaucoma.....☐Yes ☐No
Headaches.....☐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

11. Do you take pre-medication for anything?..... ☐Yes ☐No
    If you pre-medicate, what for?_____
12. Have you had any other serious illness, hospitalization or accident? .....☐Yes ☐No
    If yes, please explain:_____

Cypress Creek Dental

Adult – Medical History

Adult Medical and Dental 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
   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
   If yes, please 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
6. Are your teeth sensitive to: ☐ Nothing ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure
7. Please rate the appearance of your smile: **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
8. Would you like a whiter smile?..... ☐Yes ☐No
9. Would you like straighter teeth? ..... ☐Yes ☐No
10. Have you had your teeth straightened/worn braces? ..... ☐Yes ☐No
11. Are you concerned with bad breath? ..... ☐Yes ☐No
12. Are you concerned with grinding or clenching your teeth (bruxism)..... ☐Yes ☐No
13. Do you wear a bite guard? ..... ☐Yes ☐No
14. Are you aware of possible TMJ problems? (does your jaw make noise, lockup, or create pain) .....☐Yes ☐No
15. 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's Signature _____ **Date** _____

Dentist Signature _____ **Date** _____

Cypress Creek Dental

Adult – Dental History