IRVING FAMILY DENTAL

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? ☐ Y ☐ N

If yes, for what reason(s)? _____

4. Are you presently taking any medications/drugs/pills/herbals/supplements? ☐ Y ☐ N

If yes, please list:_____

5. (Women) Is there a chance you are pregnant? ☐ Y ☐ N

If yes, anticipated due date?_____

6. Do you take oral contraceptives? ☐ Y ☐ N

7. Are you allergic/sensitive to: (circle) None ☐ Codeine ☐ Penicillin ☐ Local Anesthetic ☐ Latex ☐ Dyes ☐ Other_____

8 Do you smoke, chew or use E-cigarettes ☐ Y ☐ N

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

9 Do you have Diabetes? ☐ Y ☐ N

If yes, please indicate ☐ Type 1 ☐ Type 2 Last HbA1c date and level_____

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

	Y	N
Heart trouble	☐	☐
Heart murmur	☐	☐
Heart surgery	☐	☐
Heart pacemaker	☐	☐
Rheumatic fever	☐	☐
Congenital heart defects	☐	☐
Artificial heart valve/stent/graft	☐	☐
Abnormal blood pressure	☐	☐
Stroke	☐	☐
Ulcers /GERD	☐	☐
Kidney trouble/Dialysis	☐	☐
Tuberculosis or lung disease	☐	☐
Asthma	☐	☐
Sinus trouble	☐	☐
Epilepsy / seizures	☐	☐
Fainting spells	☐	☐
Anemia	☐	☐
Leukemia	☐	☐

	Y	N
Excessive or prolonged bleeding	☐	☐
Thyroid problem	☐	☐
Jaundice	☐	☐
Hepatitis(Type)	☐	☐
Cancer	☐	☐
Chemotherapy/radiation	☐	☐
Arthritis	☐	☐
Artificial joint replacements	☐	☐
Cortico-Steroid treatment	☐	☐
Osteoporosis/treatment w/Bisphosphonates	☐	☐
HIV positive/AIDS	☐	☐
Oral herpetic lesions	☐	☐
Sexually Transmitted disease	☐	☐
Psychiatric care	☐	☐
Glaucoma	☐	☐
Hearing impaired	☐	☐
Chemical dependency	☐	☐
Do you take pre-medication for anything	☐	☐

If you pre-medicate, for what _____

11. Have you had any other serious illness, hospitalization or accident? ☐ Y ☐ N

If yes, please explain:_____

IRVING FAMILY DENTAL

Dental History

1. Former Dentist _____ Address _____

2. When did you last visit a dentist? _____ When was your last cleaning? _____

   X-rays taken? ☐ Y ☐ N

   If yes ☐ Full Mouth Series ☐ Bitewings ☐ Panoramic

   What was done at your last visit? _____

3. Any dental problems or concerns?

   Explain: _____

4. Have you ever been treated for gum disease? ☐ Y ☐ N
5. Is your water fluoridated? ☐ Y ☐ N
6. Are your teeth sensitive to: ☐ Nothing ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure
7. Would you like a whiter smile? ☐ Y ☐ N
8. Would you like straighter teeth? ☐ Y ☐ N
9. Have you had your teeth straightened/ worn braces? ☐ Y ☐ N
10. Are you concerned with bad breath (malodor)? ☐ Y ☐ N
11. Are you concerned with snoring or sleep apnea? ☐ Y ☐ N
12. Are you concerned with grinding or clenching your teeth (bruxism)? ☐ Y ☐ N

    Do you wear a bite guard? ☐ Y ☐ N
13. Are you aware of possible TMJ problems - does your jaw joint make noise, lock up or create pain? ☐ Y ☐ N
14. Are you interested in sleep/sedation dentistry? ☐ Y ☐ N
15. Is there anything else that would be valuable for your dentist to k w 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 _____

Medical Clearance needed: ☐ Yes ☐ No
Medical Clearance Received: ☐ Yes ☐ No
Medical Clearance Reviewed: ☐ Yes ☐ No

Dentist's Signature: _____ Date _____
Dentist's Signature: _____ Date _____
Dentist's Signature: _____ Date _____