

Mengedoth Dental, PC

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Adult Medical History

Patient Name: _____
Last First MI Preferred Name

Birth Date: _____

Physician Information:

Physician's Name, Address, City, State, Zipcode, Telephone

Date of last physical examination: _____

Have you been under the care of a physician within the past two years? Yes No

Have you had to stay overnight as a hospitalized patient in the past five years? Yes No

Are you currently taking any medication, drugs or pills (including birth control)? Yes No

Are you allergic to any medication or substance? Yes No

Have you had an allergic skin reaction to metal jewelry? Yes No

Are you a tobacco user? Yes No

Do you have a history of drug or alcohol abuse? Yes No

Have you had or currently have an eating disorder? Yes No

Are you pregnant or nursing? Yes No

If you have answered "Yes" to any of the questions above, please explain (include all current medications):

Adult Medical History (Continued)

Please indicate any conditions which you have had or are currently experiencing (check all that apply):

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Heart surgery/pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Mitral valve problems |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nervousness/anxiousness | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Artificial joints, pins or plates | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hemophilia/abnormal bleeding | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Stomach ulcers/hyperacidity | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Psychiatric/psychological care |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Cortisone medicine | <input type="checkbox"/> Neurological disorder | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Latex sensitivity | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Allergies or hives |
| <input type="checkbox"/> Fainting or dizzy spells | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cold sores/fever blisters | |

Please explain any checked responses above:

Do you have or have you had any disease, condition or problem not listed above? Yes No

If "Yes," please explain:

Response Date: ____/____/____