

Adult New Patient Medical Background Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth ____/____/____

Chief Complaint: _____

Do you have current Health Problems/ Under Physician Care Yes No

MEDICATIONS (including prescription and over the counter)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Do you have any allergies to any medications? Yes No

If yes – please list:

ALLERGIES

Local Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latex (Balloons, gloves, band-aids, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Iodine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No *
Codiene or Other Narcotics	<input type="checkbox"/> Yes <input type="checkbox"/> No		

*If yes – please list:

Have you ever had your tonsils and/or adenoids surgically removed? Yes No

PAST SURGICAL HISTORY

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

SOCIAL HISTORY

Caffeine: _____ # of cups of coffee per day _____ # of cups of tea per day
_____ # cans or glasses of soda per day _____ # of servings of chocolate per week
_____ # of energy drinks per day

Alcohol: None Yes _____ # of drinks per day _____ # of drinks per week _____ # of drinks per month

Tobacco: None Yes _____ # of packs per day _____ # of years

Recreational Drugs (such as marijuana or cocaine): None Yes

If yes, which ones? _____

Marital Status: Married Single Divorced Widowed

Children: No Yes How many? _____

Pets: No Yes How many? _____ What type of pet? _____

Do you have any children or pets that sleep in your bedroom? No Yes _____

REVIEW OF SYMPTOMS

Constitutional:

Loss of Appetite: Sweats: Yes No

Fever: Yes No

Fatigue: Yes No

Weight Gain: Yes No

Weight Loss: Yes No

Gastrointestinal:

GERD/Heartburn/Indigestion: Yes No

Black or Bloody Stools: Diarrhea: Yes No

Nausea/Vomiting: Yes No

Jaundice: Yes No

Abdominal Pain Yes No

Respiratory:

Cough: Yes No

Asthma: Yes No

Wheezing: Yes No

Poor Exercise Tolerance: Yes No

Genitourinary:

Bed Wetting: Yes No

Frequent Urination: Yes No

Difficulty Urinating: Yes No

Blood in Urine: Yes No

Erectile dysfunction Yes No

REVIEW OF SYMPTOMS

Allergy/Immunology:

- Sneezing: Yes No
- Runny Nose: Yes No
- Itchy Eyes or Nose: Hives: Yes No
- Nasal allergies/Hay fever/
Nasal Congestion Yes No

Eyes:

- Blurry Vision: Yes No
- Double Vision: Yes No
- Vision Loss: Yes No

Cardiac:

- Palpitations: Yes No
- Chest Pain: Yes No
- Daytime Shortness of Breath: Yes No
- Nighttime Shortness of Breath: Yes No
- Ankle Swelling: Yes No

Skin:

- Unusual Moles: Yes No
- Rash: Yes No
- Dryness: Yes No

Endocrine:

- Heat Intolerance: Yes No
- Excessive Thirst: Yes No
- Constipation: Yes No
- Cold Intolerance: Yes No
- Cold Hands/Feet: Yes No
- Decreased Libido: Yes No

Musculoskeletal:

- Stiff/Sore Joints: Yes No
- Muscle Pain: Yes No
- Red or Swollen Joints: Yes No
- Temporomandibular Joint
(TMJ) pain/jaw discomfort Yes No

Ears/Nose/Throat/Mouth:

- Hearing Loss: Yes No
- Sore Throat: Yes No
- Sinus Congestion: Yes No
- Hoarseness: Yes No

Neurologic:

- Weakness: Yes No
- Seizures: Yes No
- Involuntary Tongue Biting: Yes No
- Passing Out: Yes No
- Dizziness: Yes No
- Headaches: Yes No
- Numbness: Yes No
- Restless Leg Syndrome: Yes No

Psych:

- Excessive Stress: Yes No
- Memory Loss: Yes No
- Difficulty with Focus: Yes No
- Trouble Concentrating: Yes No
- Hallucinations: Yes No
- Nervousness or Anxiety: Yes No
- Depressed Mood: Yes No

HEALTH HISTORY

Do you have a personal history of any of the following medical illnesses? (Check if "yes" to all that apply):

Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis (Rheumatism)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Overweight/Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker/Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restless Leg Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic/Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> N	Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgical Implant	<input type="checkbox"/> Yes <input type="checkbox"/> N
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease or Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer/Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever taken **Bisphosphonates** such as Fosamax, Boniva, Actonel, Prolia and Xgena? Yes No

Name and Phone Number of your Physician _____

Patient Signature _____

Date: _____

Dentist Signature _____

Date: _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION