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	❑ Yes ❑ No	Antibiotics	❑ Yes ❑ No
Latex (Balloons, gloves, bandaids, etc)	❑ Yes ❑ No	Aspirin	❑ Yes ❑ No
Iodine	❑ Yes ❑ No	Other Allergies	❑ Yes ❑ No *
Codiene or Other Narcotics	❑ Yes ❑ 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

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

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

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