Time 1:22 PM | Glen Lake Dental Associates, PA | Date 1/24/2022

Adult Medical History Form (revised May 2019)

Patient Name: | Birth Date: | Date Created:

Are you currently under a physician's care? Doctor's Name/Location	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Are you on any blood thinners?	Yes No	If yes
Are you currently taking any other medications or drugs?	Yes No	If yes
Have you ever been told to take antibiotics before routine dental treatment?	Yes No	If yes
Have you ever taken bisphosphonate medications such as Fosamax, Boniva or Actonel?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Do you use tobacco or have you in the past?	Yes No	If yes
Do you use controlled substances or have you in the past?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic or sensitive to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Are you allergic or sensitive to any other medications? Please comment ☐ If yes

Do you have, or have you had, any of the following?

Congestive Heart Disease	Yes No	Diabetes	Yes No	Asthma	Yes No
Artificial Heart Valve	Yes No	Thyroid Disease	Yes No	Emphysema/COPD	Yes No
High Blood Pressure	Yes No	Kidney Disease or Dialysis	Yes No	Sinus Trouble	Yes No
Angina/Chest Pain	Yes No	Hepatitis A, B, or C	Yes No	Seasonal Allergies	Yes No
Heart Attack	Yes No	Liver Disease	Yes No	Tuberculosis	Yes No
Pacemaker/Defibrillator	Yes No	Ulcers/Colitis	Yes No	Alzheimer's/Dementia	Yes No
Artificial Joints (hip, knee, etc)	Yes No	HIV Positive/AIDS	Yes No	Depression	Yes No
Stroke/CVA	Yes No	Anemia	Yes No	Mental Health Issues	Yes No
Osteoporosis	Yes No	Blood Transfusion	Yes No	Anxiety/Nervousness	Yes No
Cancer	Yes No	Excessive Bleeding	Yes No	Parkinson's Disease	Yes No
Chemotherapy	Yes No	Hemophilia	Yes No	Epilepsy or Seizures	Yes No
Radiation Treatment	Yes No	Drug or Alcohol Addiction	Yes No	Eating Disorder	Yes No
Arthritis	Yes No	Cold Sores	Yes No		

Do you have any other conditions or diseases not listed above? Please comment Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____