Heim Carrol, DMD, LLC

2020 adult medical history form

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	○Yes ○No	If yes
Have you ever been hospitalized or had a major operation?	○Yes ○No	If yes
Are you taking any medications,herbs, supplements? if yes, please list	○Yes ○No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○Yes ○No	If yes
Do you use controlled substances?	○Yes ○No	If yes

Women: Are you...

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

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic

☐Metal ☐Latex ☐Sulfa Drugs ☐Local Anesthetics

Other allergies? Comment

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

AIDS/HIV Positive	○Yes ○No	Radiation Treatments	○Yes ○No	Diabetes	○Yes ○No	Drug Addiction	○Yes ○No
Angina	○Yes ○No	Emphysema	○Yes ○No	High Blood Pressure	○Yes ○No	Epilepsy or Seizures	○Yes ○No
Artificial Heart Valve	○Yes ○No	Artificial Joint	○Yes ○No	Asthma	○Yes ○No	Irregular Heartbeat	○Yes ○No
Kidney Problems	○Yes ○No	Stomach/Intestinal Disease	○Yes ○No	Breathing Problems	○Yes ○No	Frequent Headaches	○Yes ○No
Liver Disease	○Yes ○No	Stroke / TIA	○Yes ○No	Cancer	○Yes ○No	Lung Disease	○Yes ○No
Thyroid Disease	○Yes ○No	Chemotherapy	○Yes ○No	Mitral Valve Prolapse	○Yes ○No	Heart Attack/Failure	○Yes ○No
Osteoporosis	○Yes ○No	Tuberculosis	○Yes ○No	Cold Sores/Fever Blisters	○Yes ○No	Heart Murmur	○Yes ○No
Pain in Jaw Joints	○Yes ○No	Congenital Heart Disorder	○Yes ○No	Heart Pacemaker	○Yes ○No	Heart Trouble/Disease	○Yes ○No
Psychiatric Care	○Yes ○No	Sleep Apnea	○Yes ○No	Snoring	○Yes ○No	Daytime Sleepiness	○Yes ○No
Immune Deficiency	○Yes ○No	Bleeding Problems	○Yes ○No	Hepatitis	○Yes ○No	GERD/Acid reflux	○Yes ○No
Artificial Heart Valve	○Yes ○No	Alcohol Abuse	○Yes ○No	Anxiety	○Yes ○No	Depression	○Yes ○No
Tobacco Use	○Yes ○No						

Have you ever had any serious illness or hospitalizations not listed above? if yes, please list Comment

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:_____

Comments