

**Pear Tree Dental Medical History - Adult(Copy)**

Patient Name:

Birth Date:

Date Created:

Your mouth is part of your entire body and health conditions can have important impacts on the dentistry you receive.

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

Have you ever had a serious head or neck injury?  Yes  No If yes

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes

Do you use tobacco?  Yes  No If yes

Are you taking any medications, pills, or herbs?  Yes  No If yes

Women: Are you...

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

Are you allergic to any of the following? If yes, describe effect

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes

Do you have, or have you had, any of the following? If yes, please describe

Heart Attack <input type="radio"/> Yes <input type="radio"/> No	Angina / Chest Pain <input type="radio"/> Yes <input type="radio"/> No	Reflux / GERD <input type="radio"/> Yes <input type="radio"/> No	Liver Disease / Cirrhosis <input type="radio"/> Yes <input type="radio"/> No
Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Stroke <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Epilepsy / Seizures <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No
High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells / Dizziness <input type="radio"/> Yes <input type="radio"/> No	Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No
Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Pacemaker / Defibrillator <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Arthritis <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Hearing Problems <input type="radio"/> Yes <input type="radio"/> No	Anemia <input type="radio"/> Yes <input type="radio"/> No	Gout <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Alzheimer's / Dementia <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis / Osteopenia <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No
Depression <input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No	Anxiety <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	AIDS / HIV Positive <input type="radio"/> Yes <input type="radio"/> No	COPD <input type="radio"/> Yes <input type="radio"/> No
Low Blood Sugar <input type="radio"/> Yes <input type="radio"/> No	Hepatitis <input type="radio"/> Yes <input type="radio"/> No	Shortness of Breath <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Snoring / Obstructive Sleep Apnea <input type="radio"/> Yes <input type="radio"/> No	Cold Sores / Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Addictions <input type="radio"/> Yes <input type="radio"/> No	

Have you ever had any serious illness not listed  Yes  No If yes

Is there anything else we should know about your health that we have not covered in this form?  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: \_\_\_\_\_