Adair Family Dentistry

Healthy and Beautiful Smiles Begin Here

Patient Name: _____ Birth Date: _____ Today's Date: _____

On behalf of Dr. Will Adair and his dental team, we are pleased to welcome you to our practice. Please take a few minutes to provide us with the following information. All information will be kept confidential.

Medical History

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 _____

Are you taking any medications, pills, or drugs? ☐ 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 _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

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

If yes _____

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

AIDS/HIV Positive	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Excessive B	☐ Yes	☐ No
Angina	☐ Yes	☐ No	leeding Excessive Thirst	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No

Hives or Rash	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Pain in Jaw Joints	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Parathyroid Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Radiation Treatments	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Recent Weight Loss	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Renal Dialysis	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No			

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes _____

Comments _____

Agreement

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: _____ Date: _____