Time 12:02 PM | Chrystal T. Rooks, DDS, PA | Date 4/8/2025

Adult Medical History (Short)

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 within the last 5 years?	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
Have you been diagnosed with sleep apnea?	Yes No	If yes
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	Hemophilia	Yes No	Radiation Treatments	Yes No	Alzheimer's Disease	Yes No
Diabetes	Yes No	Hepatitis A	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No
Anemia	Yes No	Herpes	Yes No	Angina	Yes No	Emphysema	Yes No
High Blood Pressure	Yes No	Rheumatism	Yes No	Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No
High Cholesterol	Yes No	Scarlet Fever	Yes No	Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No
Artificial Joint	Yes No	Sickle Cell Disease	Yes No	Asthma/Breathing Problems	Yes No	Fainting Spells/Dizziness	Yes No
Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No	Kidney ProblemsDialysis	Yes No
Leukemia	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Glaucoma	Yes No	Lung Disease	Yes No
Thyroid Disease	Yes No	Chemotherapy/Cancer	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No
ADHD/ADD	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	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Ulcers	Yes No	Convulsions	Yes No
Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No	Autism	Yes No

Have you ever had any serious illness not listed above? 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: _____