ANN MARIE HOFBAUER, DMD
PERIODONTICS & IMPLANTOLOGY

ADULT MEDICAL HISTORY

Name _____ Date _____

Date of Birth _____ Height in feet _____ inches _____ Weight (lbs) _____

Who referred you to us? _____

Please circle your responses (YES, NO, DK = Don't Know) to indicate if you have, have not or do not know if you have had any of the following diseases or problems.

GENERAL MEDICAL INFORMATION

Name of pharmacy used _____

YES NO DK Are you, or have you been in the past year, seen by a primary care provider (regular doctor)?
If yes, please list name and Location _____

YES NO DK Are you seen by any medical specialists?
If yes, please list name(s) and location(s) _____

YES NO DK Do you need antibiotic pre-medicine prior to dental procedures?

YES NO DK Do you have active tuberculosis or have you been exposed to anyone with tuberculosis?
Specify: _____

YES NO DK Have you had heart surgery?
Specify: Stents Valves Bypass (CABG)
Other _____
Date(s) and any complications _____

YES NO DK Have you had an organ/bone marrow transplant?
Specify: Heart Lung Kidney Liver BMT
Other _____
Date(s) and any complications _____

YES NO DK Have you had an orthopedic total joint replacement?
Specify: Hip Knee
Other _____
Date(s) and any complications _____

YES NO DK Do you now or have you ever had cancer? If yes, How was it treated?
- ☐ Surgery: diagnosis, site, when _____
- ☐ Radiation: diagnosis, site, when _____
- ☐ Chemotherapy: diagnosis, site, when _____
- ☐ Medication to prevent or treat bone complications:
  Specify: _____
- ☐ Xgeva (Denosumab)
- ☐ Aredia (Pamidronate)
- ☐ Zometa (Zoledronic Acid)

  Length of time taken _____

ADULT MEDICAL HISTORY (Cont.)

GENERAL MEDICAL INFORMATION

YES NO DK Have you had any serious illness, surgery, or been hospitalized? If yes, how long ago?
- ☐ 0-12 Months Specify: _____
- ☐ 1-5 Years Specify: _____
- ☐ 5 years Specify: _____

YES NO DK Problems with general Anesthesia:
- ☐ Difficult intubation
- ☐ Malignant hyperthermia
- ☐ Prolonged/difficulty waking
- ☐ Post-operative nausea and vomiting
- ☐ Other (specify) _____

YES NO DK Do you use or have you used tobacco products?

Specify: Cigarettes E-cigarettes Cigars Pipes Hookah Snuff Chew Marijuana Other (specify) _____

PAST: When did you stop? _____ How many years of use? _____

CURRENT:
- ☐ >10 per day
- ☐ <10 per day
- ☐ Occasionally. For how many years? _____

How interested are you in stopping? Very Somewhat Not Interested

YES NO DK Do you drink alcoholic beverages? If yes, daily? YES NO DK

How many drinks per week? _____

YES NO DK Do you use or have you used street drugs, prescription or other substances for recreation purpose?

Specify:
- ☐ PAST
- ☐ CURRENT Are you dependent? YES NO DK Last Use: _____

Specify:
- ☐ COCAINE
- ☐ ECSTASY
- ☐ HEROIN
- ☐ MARIJUANA
- ☐ METH
- ☐ OPIOIDS
- ☐ Other (specify) _____

ADULT MEDICAL HISTORY (Cont.)

MEDICAL CONDITIONS

Do you have (or have you had) any of the following diseases, problems, or symptoms?

Eye/Ear/Nose/Throat Problem
YES NO DK
If yes, please specify:
☐ Vision problems
☐ Corrective lenses
☐ Cataracts
☐ Glaucoma
  ☐ Narrow angle/Open angle
☐ Macular degeneration
☐ Hearing impairment
☐ Hay fever/seasonal (allergic rhinitis)
☐ Other: _____

Heart/Blood Pressure Problem
YES NO DK
If yes, please specify:
☐ High blood pressure
☐ High cholesterol/high triglycerides
☐ Infective endocarditis
☐ Congenital heart defect/disease
☐ Angina (chest pain)
☐ Heart attack
☐ Heart failure
☐ Coronary heart disease
☐ Arrhythmia (irregular heart beat)
  ☐ Pacemaker/Implanted defibrillator
☐ Other: _____

Breathing/Lung Problem
YES NO DK
If yes, please specify:
☐ Asthma
☐ Emphysema/COPD
☐ Smusitis
☐ Bronchitis
☐ Pneumonia
☐ Obstructive sleep apnea
  ☐ Use CPAP/BiPAP
  ☐ Surgical correction
  ☐ Oral appliance
☐ Other: _____

Stomach/Intestine/Liver Disorder
YES NO DK
If yes, please specify:
☐ Acid reflux (GERD)
☐ Ulcers
☐ Crohn's disease
☐ IBS (Irritable Bowel Syndrome)
☐ Ulcerative colitis
☐ Celiac disease
☐ Hepatitis
  ☐ A ☐ B/D ☐ C
☐ Cirrhosis
☐ Other: _____

Eating Disorder
YES NO DK
If yes, please specify:
☐ Bulimia
☐ Anorexia
☐ Other: _____

Kidney/Urinary Disorder
YES NO DK
If yes, please specify:
☐ Chronic kidney disease
☐ Renal failure/Dialysis
☐ Bladder problems
☐ Urinary incontinence
☐ BPH (Benign Prostate Hypertrophy)
☐ Other: _____

Muscle/Bone Disorder
YES NO DK
If yes, please specify:
☐ Osteoarthritis
☐ Osteoporosis
☐ Osteopenia
☐ Gout
☐ Temporomandibular joint disorder
☐ Fibromyalgia
☐ Other: _____

Skin Problem
YES NO DK
If yes, please specify: _____

_____

Neurologic/Nerve Problem
YES NO DK
If yes, please specify:
☐ Stroke
☐ TIA (Transient Ischemic Attack)
☐ Seizures/Epilepsy
☐ Multiple sclerosis
☐ Parkinson's disease
☐ Neuropathies (tingling, numbness)
☐ Dementia/Alzheimer's (memory loss)
☐ Autism
☐ Headache
☐ Other: _____

Mental Health Disorder
YES NO DK
If yes, please specify:
☐ Bipolar disorder
☐ Depression
☐ Schizophrenia
☐ PTSD (Post Traumatic Stress Disorder)
☐ ADD/ADHD (Attention Deficit Disorder)
☐ Generalized anxiety disorder
☐ Panic attacks
☐ Other: _____

Diabetes/Endocrine Disorder
YES NO DK
If yes, please specify:
☐ Diabetes
  ☐ Type 1 ☐ Type 2
☐ Thyroid problems
☐ Hypothyroidism (low)
☐ Hyperthyroidism (high)
☐ Other: _____

Blood/Hematologic Disorder
YES NO DK
If yes, please specify:
☐ Anemia
☐ Sickle cell disease/trait
☐ Leukemia
☐ Lymphoma
☐ Multiple myeloma
☐ Bleeding disorders
☐ Hemophilia
☐ Von Willebrand Disease
☐ Thrombocytopenia (low platelets)
☐ Other: _____

Immune System Disorder
YES NO DK
If yes, please specify:
☐ Lupus erythematosus
☐ Rheumatoid arthritis
☐ Siogren's syndrome
☐ Other: _____

Infectious Disease
YES NO DK
If yes, please specify:
☐ HIV/AIDS
☐ STD (Sexually Transmitted Disease)
☐ Cold sores
☐ Other: _____

Do you have any other problem, disease or condition not listed above?
If yes, please specify:

_____

_____

_____

_____

_____

ADULT MEDICAL HISTORY (Cont.)

FEMALES ONLY

YES NO DK Are you or could you be pregnant?
If yes, number of weeks _____ and due date _____

YES NO DK Are you nursing?

YES NO DK Are you taking any of the following?
Specify: Birth Control Fertility Drugs Hormone Replacement

ALLERGIES TO DRUGS, LATEX, METALS OR FOODS

YES NO DK Are you allergic to or have you had a reaction to any of the following?

- ☐ Local anesthetics (Lidocaine/Epinephrine)
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Other antibiotics Specify:
- ☐ Aspirin
- ☐ Advil (Ibuprofen)
- ☐ Tylenol (Acetaminophen)
- ☐ Codeine
- ☐ Opioids (hydrocodone, oxycodone)
- ☐ Chlorhexidine mouth rinse (Peridex/Periguard)
- ☐ Other Medication(s) Specify:
- ☐ Latex (rubber)
- ☐ Metals/jewelry (nickel/chrome)
- ☐ Dietary allergies

MEDICATIONS

YES NO DK Are you taking, or are you supposed to be taking any medications - prescription, over the counter, dietary supplements, herbal medicine or vitamins? If yes, please list below.

Medications or Supplements Prescription, over-the-counter, dietary supplement, herbal medicines and vitamins	Dose (mg)	How Often? Once a day, twice a day, etc.	Reason for Use	Date Started