THE UNIVERSITY OF IOWA
COLLEGE OF DENTISTRY & DENTAL CLINICS

ADULT MEDICAL HISTORY

Name:_____
Last First Middle

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:

YES NO DK Are you, or have you been in the past year, seen by a primary care provider (PCP)?
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 have active tuberculosis or have you been exposed to anyone with tuberculosis? Specify: _____

YES NO DK Have you had heart surgery? If yes, please 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? If yes, please 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: If yes, please specify:
  - ☐ Xgeva (Denosumab) ☐ Aredia (Pamidronate) ☐ Zometa (Zoledronic Acid) Other: _____
  - Length of time taken: _____

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 Do you use or have you used tobacco products? If yes, please specify type:
CIGARETTES E-CIGARETTES CIGARS PIPES HOOKAH SNUFF CHEW OTHER:_____

- ☐ **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 prescription, street drugs or other substances for recreational purposes? (Specify):

- ☐ **PAST** ☐ **CURRENT** Are you drug dependent? **YES NO DK**
  (Specify**): COCAINE ECSTASY HEROIN MARIJUANA METH OPIOIDS Other: _____**

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

YES NO DK Eye/Ear/Nose/Throat problem

If yes, please specify:

- ☐ Vision problems
  - ☐ Cataracts
  - ☐ Glaucoma
    - ☐ Narrow angle
    - ☐ Open angle
  - ☐ Macular degeneration
- ☐ Hearing impairment
- ☐ Hay fever/seasonal (allergic rhinitis)
- ☐ Other: _____

YES NO DK Heart/Blood Pressure problem

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: _____

YES NO DK Breathing/Lung problem

If yes, please specify:

- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Obstructive sleep apnea
  - ☐ Use CPAP/BiPAP
  - ☐ Surgical correction
  - ☐ Oral appliance
- ☐ Other: _____

YES NO DK Stomach/Intestine/Liver disorder

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:_____

YES NO DK Eating disorder

If yes, please specify:

- ☐ Bulimia
- ☐ Anorexia
- ☐ Other: _____

YES NO DK Kidney/Urinary disorder

If yes, please specify:

- ☐ Chronic kidney disease
- ☐ Renal failure/Dialysis
- ☐ Bladder problems
- ☐ Urinary incontinence
- ☐ BPH (Benign Prostate Hypertrophy)
- ☐ Other:_____

YES NO DK Muscle/Bone disorder

If yes, please specify:

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Temporomandibular joint disorder
- ☐ Fibromyalgia
- ☐ Other: _____

YES NO DK Skin problem

If yes, please specify:

_____

YES NO DK Neurologic/Nerve problem

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: _____

YES NO DK Mental Health disorder

If yes, please specify:

- ☐ Bipolar disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ PTSD (Post Traumatic Stress Disorder)
- ☐ ADD/ADHD (Attention Deficit Disorder)
- ☐ Generalized anxiety disorder
- ☐ Panic attacks
- ☐ Other: _____

YES NO DK Diabetes/Endocrine disorder

If yes, please specify:

- ☐ Diabetes
  - ☐ Type 1 ☐ Type 2
- ☐ Thyroid problems
  - ☐ Hypothyroidism (low)
  - ☐ Hyperthyroidism (high)
- ☐ Other: _____

YES NO DK Blood/Hematologic disorder

If yes, please specify:

- ☐ Anemia
- ☐ Sickle cell disease/trait
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple myeloma
- ☐ Bleeding disorders
  - ☐ Hemophilia
  - ☐ Von Willebrand Disease
  - ☐ Thrombocytopenia (low platelets)
- ☐ Other: _____

YES NO DK Immune System disorder

If yes, please specify:

- ☐ Lupus erythematosus
- ☐ Rheumatoid arthritis
- ☐ Sjögren's syndrome
- ☐ Other:_____

YES NO DK Infectious disease

If yes, please specify:

- ☐ HIV/AIDS
- ☐ STD (Sexually Transmitted Disease)
- ☐ Cold sores
- ☐ Other: _____

YES NO DK Do you have any other problem, disease or condition not listed above?

If yes, please specify:

_____

_____

ANESTHETIC HISTORY

YES NO DK Anesthesia problems

- ☐ Difficult intubation
- ☐ Malignant hyperthermia
- ☐ Prolonged/difficulty waking up
- ☐ Post-operative nausea and vomiting
- ☐ Other (Specify):_____

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 OR LATEX:

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

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

Reaction(s) to above: ____

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.)	**Date Started:**	**Reason for Use:**

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ADULT DENTAL HISTORY

REASON FOR VISIT:

What is the reason for your dental visit today? **EXAMINATION EMERGENCY CONSULTATION PROCEDURE**

Specify: _____

PAST DENTAL TREATMENT:

YES NO DK Have you been to the dentist before?

If yes, how long ago was your last dental exam? **0-6 MONTHS 6-12 MONTHS 1-2 YEARS > 2 YEARS**

If yes, how long ago was your last dental x-ray? **0-6 MONTHS 6-12 MONTHS 1-2 YEARS > 2 YEARS**

If yes, how long ago was your last dental cleaning? **0-6 MONTHS 6-12 MONTHS 1-2 YEARS > 2 YEARS**

YES NO DK Do you have a history of tooth extraction or oral surgery?
(Specify): **EXTRACTIONS IMPLANTS JAW SURGERY TMJ SURGERY TRAUMA**

YES NO DK Have you had any periodontal (gum) treatments? (Specify): **DEEP CLEANING SURGERY**

YES NO DK Do you have bridges or wear dentures or partials? (Specify): **BRIDGES DENTURES PARTIALS**

YES NO DK Have you ever had root canal treatment?

YES NO DK Have you ever had orthodontic (braces) treatment?

YES NO DK Have you had a local anesthetic (Lidocaine) for dental purposes?

YES NO DK If yes, have you experienced any problems? (needle anxiety, hard to get numb, etc.)

YES NO DK Have you had any problems associated with previous dental treatment?

YES NO DK Has fear ever prevented you from seeking dental care?

DENTAL PROBLEMS (SIGNS/SYMPTOMS):

YES NO DK Are you currently experiencing dental pain or discomfort?
If yes, is it causing headaches, earaches or neck pains? (Specify): **HEADACHES EARACHES NECK PAINS**

YES NO DK Are your teeth sensitive to cold, hot, sweets or pressure? (Specify): **COLD HOT SWEETS PRESSURE**

YES NO DK Do you have problems with eating? (Specify): **TROUBLE CHEWING SWALLOWING VOMITING OTHER**

YES NO DK Do you have swelling in or around your mouth, face or neck? (Specify): **MOUTH FACE NECK**

YES NO DK Do you have loose teeth?

YES NO DK Do you have any clicking, popping, discomfort, or limited opening in the jaw?
(Specify): **CLICKING POPPING DISCOMFORT LIMITED OPENING**

YES NO DK Do you have or have you had sores or ulcers in your mouth? If yes, location:_____

YES NO DK Have you ever injured your face, jaws or teeth?

YES NO DK Are you unhappy with your smile or the appearance of your teeth?

YES NO DK Do you have a bad taste or bad breath? (Specify): **BAD TASTE BAD BREATH**

YES NO DK Do you experience dry mouth?

DENTAL DISEASE PREVENTION (ORAL HYGIENE):

How often and when do you brush your teeth? **NEVER SOMETIMES 1x/WEEK 1x/DAY 2x/DAY > 2x/DAY AM PM**

How often do you floss your teeth? **NEVER SOMETIMES 1x/WEEK 1x/DAY > 1x/DAY**

Do your gums bleed when you brush or floss? **NEVER SOMETIMES ALWAYS**

ORAL HABITS:

YES NO DK Do you clench, brux, or grind your teeth? (Specify): **CLENCH BRUX/GRIND BOTH**

YES NO DK Do you chew on ice or potentially damaging objects (pencils, bottle caps, etc)? (Specify): **ICE OBJECTS BOTH**