UNIVERSITY of ROCHESTER MEDICAL CENTER

Patient Name ______________________ EDC Record No. ☐☐☐☐—☐☐

Date of Birth ____ / ____ / ____

Adult Dental And Medical History

Who is your medical doctor? ______________________ Date of last medical exam? ____________

Medical Doctor's address ______________________ Medical Doctor's phone no. ____________

	NO	YES
Are you under a medical doctor's care now? (If YES, see below) .... If yes, for what? ____________	☐	☐
What MEDICATIONS are you currently taking? (If any, list below) .... Medications: ____________	☐	☐

If female, are you pregnant or nursing? No ☐ Yes ☐ Do you smoke, use chewing tabacco or snuff? (circle which one) No ☐ Yes ☐

CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	AIDS/ARC/HIV Pos.	Eating Disorder	Chemotherapy (Cancer, Leukemia)
Angina Pectoris	Hepatitis A (Infectious)	Bruise Easily	Venereal Disease (Syphilis, Gonorrhea, etc.)
High Blood Pressure	Hepatitis B (Serum)	Emphysema	Alcoholism
Heart Murmur	Liver Disease Hepatitis C	Tuberculosis (TB)	Injury caused by another person
Rheumatic Fever	Blood Transfusion	Asthma	Cortisone Medicine
Congenital Heart Lesions	Drug Addiction	Hay Fever	Pain in Jaw Joints
Mitral Valve Prolapse	Sickle Cell Disease	Sinus Trouble	Ulcers
Artificial Heart Valve	Hemophilia (Bleeding Problems)	Allergies or Hives	Anemia
Heart Pacemaker	Epilepsy or Seizures	Diabetes	Stroke
Heart Surgery	Nervousness	Thyroid Disease	Kidney Trouble
Other Heart Problems	Psychological/Emotional Treatment	Radiation Treatment	Other ____________
Artificial Joints (Hip, Knees, Other)	Glaucoma	Arthritis	

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING: (please circle)

Aspirin Codeine	Nitrous Oxide Local Anesthetics	Penicillin Erythromycin	Sulfa Sedatives	Barbiturates Metal	Latex

Other medicines or substances? or No Known Allergies (Circle)

Dentist Name ____________ Phone # ____________ Address ____________

How long since your last dental visit? ____________ Last full mouth x-ray? ____________

	NO	YES
Do your gums bleed or feel tender or irritated? (circle if any symptom)	☐	☐
Are you aware of grinding or clenching your teeth?	☐	☐
Does your jaw click when you open your mouth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do you wear dentures (circle) partials or full (uppers, lowers, both)?	☐	☐
Do you use dental floss daily?	☐	☐

Do you have any of the following problems or concerns? (circle)

pain   teeth appearance   poor denture fit/retention   tooth sensitivity

To the best of my knowledge, the above questions have been answered accurately. I hereby consent to the initial examination, including the taking of diagnostic radiographs (x-rays), photographs and casts as deemed necessary by Eastman Dental Center.

____________ Date   ____________ Signature (self or parent/guardian)

FOR PROVIDER'S USE ONLY

Summary of medical history/medical problems affecting dental treatment: ____________

Vital Signs: Blood Pressure ____________ Pulse Rate ____________

Hx obtained from ____________ Reviewed by ____________ Date ____________

DDS/DMD/RDH

Form No. EDC20720 (03SA98)

R.R. DONNELLEY