Adults Medical History(Final)

Patient Name: Birth Date: Date Created:

Welcome to Corsi Dental

Any health problems or medications could have an important interrelationship with dentistry. In order for us to treat you safely, please answer all questions.

Last Dental Visit/Cleaning/X-ray?	☐	If yes
What is your main dental concern?	☐	If yes
If you're anxious, how can we help?	○ Yes ○ No	If yes
Have you had braces?	○ Yes ○ No	If yes
Have you had periodontal (gum) treament?	○ Yes ○ No	If yes
Have you had your wisdom teeth removed?	○ Yes ○ No	If yes
Do you require Antibiotic Pre-medication for any heart or joint condition?	○ Yes ○ No	If yes

Emergency Contact (Name/Number)

Medical Doctor's (Name/Number)

Previous Dentist

Pharmacy's (Name/Number)

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

If pregnant please provide Due Date and OB/GYN: ☐ If yes

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other - Please List

Are you recovering/addicted to Drugs or Alcohol? ○ Yes ○ No

Do you use any tobacco products? (How Much/ ○ Yes ○ No

Do you have a history of any of the following?

High Blood Pressure ○ Yes ○ No	Organ Transplant ○ Yes ○ No	Diabetes I or II ○ Yes ○ No	AIDS/HIV Positive ○ Yes ○ No
Low Blood Pressure ○ Yes ○ No	Congenital Heart Issue ○ Yes ○ No	TMJ Disorder ○ Yes ○ No	Herpes ○ Yes ○ No
Heart Attack ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Grinding of Teeth ○ Yes ○ No	Venereal Diseases ○ Yes ○ No
Stroke ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Hepatitis B ○ Yes ○ No
Heart Murmur ○ Yes ○ No	Asthma ○ Yes ○ No	Kidney Disease ○ Yes ○ No	Hepatitis C ○ Yes ○ No
Mitral Valve Prolapse ○ Yes ○ No	Emphysema/COPD ○ Yes ○ No	Renal Dialysis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Heart Pacemaker ○ Yes ○ No	Lung Disease ○ Yes ○ No	Liver Cirrohsis ○ Yes ○ No	Arthritis/Gout ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Shortness of Breath ○ Yes ○ No	Thyroid Disease ○ Yes ○ No	Alzheimer's Disease ○ Yes ○ No
Sickle Cell Anemia ○ Yes ○ No	Gastric Bypass ○ Yes ○ No	Glaucoma ○ Yes ○ No	Psychiatric Disorder ○ Yes ○ No
Anemia ○ Yes ○ No	Cancer ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Developmental Delay ○ Yes ○ No
Hemophilia ○ Yes ○ No	Chemotherapy ○ Yes ○ No	Stomach Ulcers ○ Yes ○ No	Mentally Disabled ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Radiation ○ Yes ○ No	Dry Mouth ○ Yes ○ No	Epilepsy/Seizures ○ Yes ○ No
High Cholesterol ○ Yes ○ No	Leukemia ○ Yes ○ No	Sjogren's Syndrome ○ Yes ○ No	Artificial Joint ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Bone Cancer ○ Yes ○ No	Myeloma ○ Yes ○ No	Metal Rods/Pins ○ Yes ○ No
Swollen Limbs ○ Yes ○ No	Osteogenesis ○ Yes ○ No	Paget's Syndrome ○ Yes ○ No	Head/Neck/Back Inj. ○ Yes ○ No

Please List Any Other Illnesses, Surgeries or Hospitalizations (Why/When)

Current Medication List:

Have you ever used any Bisphosphonate meds such as: Fosamax, Aredia, Actonal, Zometa, Boniva? ○ Yes ○ No

Have you used any weight loss medications such as: Fen-Phen/Redux? ○ Yes ○ No

Have you ever been diagnosed with Sleep Apnea or used a CPAP machine? ○ Yes ○ No

To the best of my knowlege, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the doctor and his team to take x-rays, study models, videos and photographs. I authorize the doctor and his team to perform ANY and ALL forms of treatment, use local anesthetic and any other medical therapy deemed necessary. I understand I am responsible for payments of dental services for myself and my dependents, payable at the time of service unless otherwise arranged. Corsi Dental Associates accepts insurance assignemnts as a courtesy to me and I am responsible for any cost the insurance does not pay. At Corsi Dental Associates we are dedicated to staying on schedule for the benefit of our patients. We ask that you help us by arriving on time for all appointments. We require 24 hours notice if you must cancel/change your appointment and all appointments should be confirmed.

Signature of Patient, Parent or Guardian:

X Date:_____