

# Adult New Patient Medical Background Information

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Chief Complaint: \_\_\_\_\_

## MEDICATIONS (including prescription and over-the-counter)

1. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 6. \_\_\_\_\_

3. \_\_\_\_\_ 7. \_\_\_\_\_

4. \_\_\_\_\_ 8. \_\_\_\_\_

Do you have any allergies to any medications?  Yes  No

If yes – please list:

\_\_\_\_\_  
\_\_\_\_\_

## PAST SURGICAL HISTORY

1. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 6. \_\_\_\_\_

3. \_\_\_\_\_ 7. \_\_\_\_\_

4. \_\_\_\_\_ 8. \_\_\_\_\_

Have you ever had your tonsils and/or adenoids surgically removed?  Yes  No

## SOCIAL HISTORY

**Caffeine:** \_\_\_\_\_ # of cups of coffee per day \_\_\_\_\_ # of cups of tea per day  
\_\_\_\_\_ # cans or glasses of soda per day \_\_\_\_\_ # of servings of chocolate per week  
\_\_\_\_\_ # of energy drinks per day

**Alcohol:**  None  Yes \_\_\_\_\_ # of drinks per day \_\_\_\_\_ # of drinks per week \_\_\_\_\_ # of drinks per month

**Tobacco:**  None  Yes \_\_\_\_\_ # of packs per day \_\_\_\_\_ # of years

**Recreational Drugs (such as marijuana or cocaine):**  None  Yes

If yes, which ones? \_\_\_\_\_

**Marital Status:**  Married  Single  Divorced  Widowed

**Children:**  No  Yes How many? \_\_\_\_\_

**Pets:**  No  Yes How many? \_\_\_\_\_ What type of pet? \_\_\_\_\_

**Do you have any children or pets that sleep in your bedroom?**  No  Yes \_\_\_\_\_

## REVIEW OF SYMPTOMS

### Constitutional:

Loss of Appetite: Sweats:  Yes  No

Fever:  Yes  No

Fatigue:  Yes  No

Weight Gain:  Yes  No

Weight Loss:  Yes  No

### Gastrointestinal:

GERD/Heartburn/Indigestion:  Yes  No

Black or Bloody Stools: Diarrhea:  Yes  No

Nausea/Vomiting:  Yes  No

Jaundice:  Yes  No

Abdominal Pain  Yes  No

### Respiratory:

Cough:  Yes  No

Asthma:  Yes  No

Wheezing:  Yes  No

Poor Exercise Tolerance:  Yes  No

### Genitourinary:

Bed Wetting:  Yes  No

Frequent Urination:  Yes  No

Difficulty Urinating:  Yes  No

Blood in Urine:  Yes  No

Erectile dysfunction  Yes  No

## REVIEW OF SYMPTOMS

### Allergy/Immunology:

- Sneezing:  Yes  No
- Runny Nose:  Yes  No
- Itchy Eyes or Nose: Hives:  Yes  No
- Nasal allergies/Hay fever/  
Nasal Congestion  Yes  No

### Eyes:

- Blurry Vision:  Yes  No
- Double Vision:  Yes  No
- Vision Loss:  Yes  No

### Cardiac:

- Palpitations:  Yes  No
- Chest Pain:  Yes  No
- Daytime Shortness of Breath:  Yes  No
- Nighttime Shortness of Breath:  Yes  No
- Ankle Swelling:  Yes  No

### Skin:

- Unusual Moles :  Yes  No
- Rash:  Yes  No
- Dryness:  Yes  No

### Endocrine:

- Heat Intolerance:  Yes  No
- Excessive Thirst:  Yes  No
- Constipation:  Yes  No
- Cold Intolerance:  Yes  No
- Cold Hands/Feet:  Yes  No
- Decreased Libido:  Yes  No

### Musculoskeletal:

- Stiff/Sore Joints:  Yes  No
- Muscle Pain:  Yes  No
- Red or Swollen Joints:  Yes  No
- Temporomandibular Joint  
(TMJ) pain/jaw discomfort  Yes  No

### Ears/Nose/Throat/Mouth:

- Hearing Loss:  Yes  No
- Sore Throat:  Yes  No
- Sinus Congestion:  Yes  No
- Hoarseness:  Yes  No

### Neurologic:

- Weakness:  Yes  No
- Seizures:  Yes  No
- Involuntary Tongue Biting:  Yes  No
- Passing Out:  Yes  No
- Dizziness:  Yes  No
- Headaches:  Yes  No
- Numbness:  Yes  No
- Restless Leg Syndrome:  Yes  No

### Psych:

- Excessive Stress:  Yes  No
- Memory Loss:  Yes  No
- Difficulty with Focus:  Yes  No
- Trouble Concentrating:  Yes  No
- Hallucinations:  Yes  No
- Nervousness or Anxiety:  Yes  No
- Depressed Mood:  Yes  No

## FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if “yes” to all that apply):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> High blood pressure/hypertension | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Chronic insomnia       |
| <input type="checkbox"/> Heart disease                    | <input type="checkbox"/> Overweight/obesity | <input type="checkbox"/> Restless legs syndrome |
| <input type="checkbox"/> Stroke                           | <input type="checkbox"/> Snoring            | <input type="checkbox"/> Multiple sclerosis     |
| <input type="checkbox"/> Congestive heart failure         | <input type="checkbox"/> Sleep apnea        | <input type="checkbox"/> Sleep walking          |
| <input type="checkbox"/> Depression                       | <input type="checkbox"/> Anxiety            |   |

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date: \_\_\_\_\_

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION**