Adult Medical History Form: Please fill out and sign at the bottom.

Name_____ email address_____

Preferred _____DOB___/___/____ M / F When was your last dental visit?_____

SS#_____-_____-_____ Occupation_____ Why have you come to the dentist today?_____

Home Address_____ _____

_____ How often do you brush?_____ floss?_____

Hm Ph(____)_____ Wk Ph(____)_____ Rate your current dental health_____

Employer_____ Physician _____ph(____)_____

Spouse_____ Rate your current medical health_____

Preferred _____DOB___/___/____ M / F List any Allergies_____

SS# _____-____-_____ Occupation_____ _____

Employer_____ Current Medications_____

Referred by_____ _____

Have you ever had any of the following:

Y / N – Abnormal Bleeding
Y / N – Alcohol / Drug Abuse
Y / N – Anemia
Y / N – Arthritis
Y / N – Artificial Joints / Valves
Y / N – Asthma
Y / N – Blood Transfusion
Y / N – Cancer / Chemotherapy
Y / N – Colitis
Y / N – Congenital Heart Defect
Y / N – Diabetes
Y / N – Difficult Breathing
Y / N – Emphysema
Y / N – Fainting Spells
Y / N – Frequent Headaches
Y / N - Glaucoma

Y / N – Hay Fever
Y / N – Heart Attack
Y / N – Heart Murmur
Y / N – Heart Surgery
Y / N – Hemophilia
Y / N – Hepatitis
Y / N – Herpes / Fever Blisters
Y / N – High Blood Pressure
Y / N – HIV+ / AIDS
Y / N – Hospitalized
Y / N – Kidney Problems
Y / N – Liver Disease
Y / N – Low Blood Pressure
Y / N – Mitral Valve Prolapse
Y / N – Pacemaker
Y / N – Psychiatric Problems

Y / N – Radiation Treatment
Y / N – Rheumatic / Scarlet Fever
Y / N – Seizures
Y / N – Shingles
Y / N – Sickle Cell Disease / Traits
Y / N – Sinus Trouble
Y / N – Stroke
Y / N – Thyroid Problems
Y / N – Tuberculosis
Y / N – Ulcers
Y / N – Venereal Disease
Other_____
_____
_____
_____
_____

Drug Allergies? Please circle or list:_____
_____

….Penicillin…..……Erythromycin……..…Tetracycline…..……Codeine…..……Aspirin…..……Sulfa drugs…..

For Women: …. Are you taking birth control medication? Y / N Are you pregnant? Y / N ….in _____month

This information is true to the best of my knowledge. Signed _____ date _____

Emergency contact person _____ph_____relationship_____

Leonard Fu, DMD, FAGD **515 South Drive, Suite 10A** Mountain View, CA 94040 **(650) 969-8452**