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

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Tobacco: ❑ None ❑ Yes _____ # of packs per day _____ # of years

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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

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

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

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):

- ❑ High blood pressure/hypertension
- ❑ Heart disease
- ❑ Stroke
- ❑ Congestive heart failure
- ❑ Depression
- ❑ Diabetes
- ❑ Overweight/obesity
- ❑ Snoring
- ❑ Sleep apnea
- ❑ Anxiety
- ❑ Chronic insomnia
- ❑ Restless legs syndrome
- ❑ Multiple sclerosis
- ❑ Sleep walking

Patient Signature _____ Date: _____

Dentist Signature _____ Date: _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION