Dr. Mark Evans
Adult Patient Form

Name: _____ **Preferred Name:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Date of Birth: ___/___/___ **Sex: M/F** **Weight** ____ **Height**_____

Marital Status: (circle one) Single Married Divorced Widow

Employer: _____ **Occupation:** _____

Name of Spouse: _____ **Emergency Contact/number:** _____

Whom may we thank for referring you? _____

PLEASE CIRCLE YES OR NO

1. **Are you in good health? YES / NO**
2. **Has there been any change in your health in the past year? YES / NO**
   If yes, please explain _____
3. **Date of last physical** _____ **Physician name and #** _____
4. **Are you under the care of a physician? YES / NO If Yes, please explain** _____
5. **Have you had any operation, illness, or been hospitalized in past 5yrs? YES / NO**
   If yes, please explain _____
6. **Have you ever been told to premedicate prior to a dental visit? YES / NO**
   If yes, please list drug name and dosage _____
7. **History of alcohol or drug abuse? YES / NO**
8. **Are you taking or scheduled to take alendondrate (Fosamax), risedronate (Actonel), or Boniva? YES / NO**

Please check if you have had or have any of these conditions or symptoms

ENDOCRINE/IMMUNE			
Diabetes	❑	Hypoglycemia	❑
Hypothyroidism	❑	Excessive hunger or thirst	❑
Hyperthyroidism	❑	Slow Healing/Anemia	❑
Aids/HIV	❑	Abnormal bleeding/bruising	❑
Significant weight loss/gain	❑	Sexually transmitted diseases	❑
HEART			
Heart Attack	❑	High Cholesterol	❑
High/Low Blood Pressure (Circle)	❑	Chest pain upon exertion	❑
Stroke	❑	Mitral Valve Prolapse	❑
Congestive Heart Failure	❑	Pacemaker/Defibrillator	❑
Heart Murmur	❑	Rheumatic Fever	❑
Cardiac Valve replacement	❑	Blood transfusion date: _____	❑
LIVER/KIDNEY			
Hepatitis A, B, or C	❑	Pancreatitis	❑
Jaundice	❑	Elevated liver enzymes	❑
Renal Dialysis	❑		

GASTROINTESTINAL

Ulcers	❑	Frequent heartburn	❑
Acid reflux disease	❑	Crohn's disease	❑
Irritable Bowel Syndrome	❑	Colitis	❑

MUSCULOSKELETAL

Rheumatoid Arthritis	❑	Multiple Sclerosis	❑
Neuropathy	❑	Cerebral Palsy	❑
Lupus	❑	Chronic Pain	❑
Fibromyalgia	❑	Joint Replacement	❑
Parkinson's	❑		

CANCER

Blood Cancers	❑	Open/closed shunt or port	❑
Tumors/growths	❑	Radiation treatment	❑
Chemotherapy	❑		

NEUROLOGICAL

Depression	❑	Epilepsy	❑
Anxiety	❑	Sleep disorder	❑
High Stress	❑	Fainting spells/seizures	❑
Bipolar disorder	❑	Severe headaches/migraines	❑
Alzheimer's	❑		

RESPIRATORY

Asthma	❑	Tuberculosis	❑
Lung disease	❑	Bronchitis	❑
COPD/Emphysema	❑	Sinus problem	❑
Sleep Apnea/Snoring	❑		

ALLERGIES

Local anesthetics	❑	Metals/Acrylics	❑
Aspirin	❑	Latex	❑
Penicillin or other antibiotics	❑	Iodine	❑
Sedatives	❑	Animals: _____	❑
Sulfa drugs	❑	Hay fever/seasonal	❑
Codeine or other narcotics	❑	Foods (list)	❑
other_____	❑	_____	

Are you wearing contact lenses/glasses? YES / NO
Do you have glaucoma? _____

Women:

Are you pregnant? YES / NO How many weeks/months_____
Are you nursing? YES / NO
Are you taking birth control or hormone replacements? YES / NO

DENTAL INFORMATION

Please circle YES or NO

1. **Do your gums bleed when you brush or floss? YES / NO**
2. **Are your teeth sensitive to cold, sweets or pressure? YES / NO**
3. **Does food, pack or floss catch between your teeth? YES / NO**
4. **Is your mouth dry? YES / NO**
5. **Have you had any periodontal (gum) treatment? YES / NO**
6. **Have you ever had ortho (braces) treatment? YES / NO**
7. **Any problems with previous dental treatment? YES / NO**
   If yes, please explain _____
8. **Is your home water fluoridated? YES / NO**
9. **Do you drink bottled or filtered water? YES / NO**
10. **Are you currently experiencing pain or discomfort? YES / NO**
11. **What is the reason for your dental visit today? _____**
12. **Do you have earaches or neck pain? YES / NO**
13. **Do you have any clicking, popping, or discomfort in your jaw? YES / NO**
14. **Do you have sores or ulcers in your mouth? YES / NO**
15. **Do you wear dentures or partials? YES / NO**
16. **Have you ever had any serious injury to your face or head? YES / NO**
17. **Do you smoke or use smokeless tobacco? YES / NO**

Signature: _____ Date: _____

Clinician Notes: _____

_____

UPDATES: _____ _____

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