Medical history Date_____ Print name: _____

Please check the following that apply to you: Please Check YES or NO

YES	NO	
☐	☐	AIDS
☐	☐	Alzheimer's disease
☐	☐	Anemia
☐	☐	Angina/ chest pain
☐	☐	Arthritis
☐	☐	Artificial joints
☐	☐	Asthma
☐	☐	Bleeding problem
☐	☐	Blind
☐	☐	Bone plates/ screws
☐	☐	Breathing problems
☐	☐	Bronchitis
☐	☐	Bruise easily
☐	☐	Bruxism
☐	☐	Cancer_____
☐	☐	Cerebral palsy
☐	☐	Congenital heart disease
☐	☐	Convulsion/ epilepsy
☐	☐	Cortisone medicine
☐	☐	Crohn's disease
☐	☐	Deaf
☐	☐	Diabetes
☐	☐	Digestive tract ulcer

YES	NO	
☐	☐	Ear ache
☐	☐	Emphysema
☐	☐	Excessive bleeding
☐	☐	Fainting/ dizziness
☐	☐	Genital herpes
☐	☐	Glaucoma
☐	☐	Gout
☐	☐	Head injury
☐	☐	Headaches
☐	☐	Hearing problem
☐	☐	Heart attack/ failure
☐	☐	Heart disease
☐	☐	Heart murmur
☐	☐	Heart surgery
☐	☐	Heart valve problems
☐	☐	Hepatic infection
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High blood pressure
☐	☐	History of drug abuse
☐	☐	HIV positive

YES	NO	
☐	☐	Hives/ rash
☐	☐	Implants_____ _____
☐	☐	Kidney problems
☐	☐	Leukemia
☐	☐	Liver disease
☐	☐	Nervous disorder
☐	☐	Nervous of dentist
☐	☐	On dialysis
☐	☐	Pacemaker
☐	☐	Pain in the jaw joint
☐	☐	Parathyroid disease
☐	☐	Pneumonia
☐	☐	Portal hypertension
☐	☐	Prosthetic hip or joint
☐	☐	Psychiatric care
☐	☐	Recent blood transfusion
☐	☐	Respiratory disease
☐	☐	Rheumatic fever
☐	☐	Rheumatic heart disease
☐	☐	Rheumatism

YES	NO	
☐	☐	Seizures
☐	☐	Shortness of breath
☐	☐	Sickle cell disease
☐	☐	Skin sores/ blisters
☐	☐	Stomach ulcers or colitis
☐	☐	Stroke (year_____)
☐	☐	Swelling of limbs
☐	☐	Thyroid problem
☐	☐	Trying to get pregnant
☐	☐	Tuberculosis
☐	☐	Tumor or growths
☐	☐	Venereal disease
☐	☐	Wheelchair patient
☐	☐	Other_____
☐	☐	_____
		For Woman Only:
☐	☐	Pregnant months_____
☐	☐	Nursing
☐	☐	Is there a chance you may be pregnant?

Reason for today's visit:

_____

List and/or Explain Other Medical Conditions not listed above:

_____

Do you have any Allergies? Please check YES or NO.

YES	NO	
☐	☐	Acrylic
☐	☐	Acetaminophen
☐	☐	Amoxicillin
☐	☐	Iodine

YES	NO	
☐	☐	Latex
☐	☐	Aspirin
☐	☐	Penicillin
☐	☐	Vicodin

YES	NO	
☐	☐	Sulfa
☐	☐	Lidocaine
☐	☐	Codeine
☐	☐	Epinephrine

YES	NO	
☐	☐	Metal; type_____
☐	☐	Ibuprofen
☐	☐	Other _____

Are you taking any of the following? Please check YES or NO

YES NO YES NO YES NO

☐ ☐ Aspirin/Blood thinners ☐ ☐ Bisphosphonate Reason: _____ ☐ ☐ Blood pressure medicine

☐ ☐ Cortisone (Steroids) ☐ ☐ Insulin, tolbutamide (orinase) or similar drugs ☐ ☐ Oral contraceptive

☐ ☐ Drugs for heart trouble ☐ ☐ Radiation therapy –reason _____

Do you take any other medications? Yes [ ] NO [ ] (if yes please list all Medications) _____ _____

_____ _____ _____ _____

Have you had a serious illness/operation or hospitalization? YES [ ] NO [ ] If YES what year? _____

Explain reason and condition _____

Due to pre-existing medical conditions, is pre-medication required for dental treatment? YES [ ] NO [ ] If *yes, please specify medication and its instructions* _____ By signing below, I acknowledge that I have read and understand the above medical questionnaire. That the information on this form provided is essential to determine my medical/cosmetic needs and provision of the treatment plan and that I will have the opportunity to discuss my health history with my doctor during this appointment. If any changes occur in my health/history I will report it to the office as soon as possible in writing. I acknowledge that all answers have been truthful and I will not hold any of the staff responsible for any error or omissions that I have made in the completion. I consent to the examination and/or treatment of myself and all minor children listed, to Arizona Dental Management personnel.

Print Name _____ Date: _____

Patient Signature _____ Relationship _____

Doctor Signature _____ *Date:* _____