SUN CITY DENTAL

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
Name of Physician / and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitaliziation for illness or injury_____	☐	☐
2. an allergic reaction to		
☐ aspirin		
☐ ibuprofen		
☐ acetaminophen		
☐ codeine		
☐ penicillin		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent in the last 6 months _	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artifical heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artifical prosthesis (heart valve or joints) _____	☐	☐
8. high or low blood pressure _____	☐	☐
9. a stroke (taking blood thinner) _____	☐	☐
10. anemia or other blood disorder _____	☐	☐
11. prolonged bleeding due to a slight cut (NR>3.5)____	☐	☐
12. emphysema, sarcoidosis _____	☐	☐
13. tuberculosis _____	☐	☐
14. asthma _____	☐	☐
15. breathing or sleeping problems (i.e. snoring, sinus) _	☐	☐
16. kidney disease _____	☐	☐
17. liver disease _____	☐	☐
18. jaundice _____	☐	☐
19. thyroid, parathyroid disease, or calcium deficiency __	☐	☐
20. hormone deficiency _____	☐	☐
21. high cholesterol or taking statin drugs _____	☐	☐

	YES	NO
22. diabetes (HbA1c=_____) _____	☐	☐
23. stomach or duodenal ulcer _____	☐	☐
24. digestive disorders (i.e. gastric reflux) _____	☐	☐
25. osteoporosis/osteopenoa(i.e. taking bisphosphonates)	☐	☐
26. arthritis _____	☐	☐
27. glaucoma _____	☐	☐
28. contact lenses _____	☐	☐
29. epilepsy, convulsions (seizures) _____	☐	☐
30. neurologic problems _____	☐	☐
31. viral infections and cold sores _____	☐	☐
32. any lumps or swelling in the mouth _____	☐	☐
33. hives, skin rash, hay fever _____	☐	☐
34. hepatitis (type ____) _____	☐	☐
35. HIV / AIDS _____	☐	☐
36. tumor, abnormal growth _____	☐	☐
37. radiation therapy _____	☐	☐
38. chemotherapy _____	☐	☐
39. psychiatric treatment _____	☐	☐
40. alcohol / drug dependency _____	☐	☐
41. new cough, fever or diarrhea _____	☐	☐
42. recent exposure to an infectious disease _____	☐	☐
ARE YOU:		
43. presently being treated for any other illness _____	☐	☐
44. aware of a change in your general health _____	☐	☐
45. taking dietary supplements _____	☐	☐
46. subject to frequent headaches _____	☐	☐
47. a smoker or smoked previously _____	☐	☐
48. FEMALE - taking birth control pills _____	☐	☐
49. FEMALE - pregnant _____	☐	☐
50. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than six medications.

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____