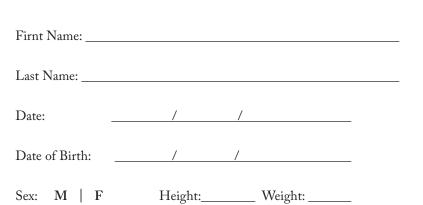
MEDICAL HISTORY FORM



	ESTETICA COSMETIC & RECONSTRUCTIVE SURGERY OF SCOTTSDALE
	Practice Administrator
,	9450 E Ironwood Square Dr.
	0 1.1 05050

Scottsdale, AZ 85258 Phone: (480) 551-0581 Fax: (480) 551-0585 www.anewbeautifulyou.com

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1.	Are you in good health?			No
2.	Has there been any change in your health in the past year?			No
3.	My last physical exam was on			/
4.	Are you now under the care of a physician?			No
	If so, for what condition?			
5.	The name and address of my physician is:			
6.	Have you had any serious illness, significant operation or hospitalization within the past 5 years?	Yes		No
7.	Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills	Yes		No
	If so, please list			
8.	Do you have or have you had any of the following diseases or problems?			
	a. Damaged heart valves, artificial valves or heart murmur	Yes		No
	b. Rheumatic Heart Disease	Yes		No
	c. Heart trouble, heart attack, angina, high blood pressure, stroke, Arteriosclerosis or any other heart condition			

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2. Shortness of breath after mild exercise? 3. Do your ankles swell? 4. Allergies 4. Allergies 5. Sinus trouble 6. Asthma or hay fever 7. Sinus trouble 7. Asthma or hay fever 8. Fainting spells or scizures 8. Fainting spells or scizures 9. Fainting spells or scizures 9. Fainting spells or scizures 9. Frequent or recurring mouth sores 9. Frequ		
3. Do your ankles swell? d. Allergies e. Sinus trouble f. Asthma or hay fever g. Fainting spells or seizures h. Diabetes yes No. h. Diabetes i. Hepatitis, jaundice or liver disease j. Frequent or recurring mouth sores k. Thyroid problems Respiratory problems, emphysema, bronchitis, etc. m. Arthritis or painful, swollen joints including jaw joint (TMJ) v. Stomach ulcer or hyperacidity o. Kidney trouble yes No. v. Persistent cough or cough that produces blood r. Persistent swollen neck glands s. Low blood pressure t. Epilepsy or neurological disorder u. Are you taking vitamins or homeopathic remedies v. Cancer v. Any disease, drug or transplant operation that has depressed your immune system Have you ever had treatment for a tumor or growth? Are you allergic to or have you had a reaction to: a. Local anesthetics yes No. No. No. Penicillin or antibiotics yes No. No. No. Penicillin or antibiotics yes No. No. No. Penicillin or antibiotics yes No. No. Penicillin or antibiotics yes No. No. Penicillin or antibiotics	1. Chest pain upon exertion?	Yes No
d. Allergies Yes No. e. Sinus trouble Yes No. f. Asthma or hay fever g. Fainting spells or seizures h. Diabetes 1. Hepatitis, jaundice or liver disease j. Frequent or recurring mouth sores k. Thyroid problems Respiratory problems, emphysema, bronchitis, etc. Thyroid problems 1. Respiratory problems 1. Respiratory problems, emphysema, bronchitis, etc. Thyroid problems 1. Respiratory p	2. Shortness of breath after mild exercise?	Yes No
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w. Any disease, drug or transplant operation that has depressed your immune system Yes Note Not	u. Are you taking vitamins or homeopathic remedies	Yes No
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Have you ever had treatment for a tumor or growth? Are you allergic to or have you had a reaction to: a. Local anesthetics Yes No. 2000	a. Have you ever required a blood transfusion?	Yes No
Are you allergic to or have you had a reaction to: a. Local anesthetics Yes No. Denicillin or antibiotics Yes No. Yes No	Do you have any blood disorder such as anemia?	Yes No
a. Local anesthetics Yes No. Denicillin or antibiotics Yes No. Denicillin or antibiotics	Have you ever had treatment for a tumor or growth?	Yes No
b. Penicillin or antibiotics Yes No	Are you allergic to or have you had a reaction to:	Yes No
	a. Local anesthetics	Yes No
c. Sulfa drugs	b. Penicillin or antibiotics	Yes No
	c. Sulfa drugs	Yes No

	d. Barbiturates or sleeping pills	Yes		No
	e. Aspirin	Yes		No
	f. Iodine	Yes		No
	g. Codeine or other narcotics	Yes		No
	h. Latex or rubber products	Yes		No
	i. Other	Yes		No
13.	Have you had any serious trouble associated with previous dental treatment?	Yes		No
	If so, explain:			
14.	Do you have any other condition or disease you think the doctor should know about?	Yes		No
	If so, explain:			
15.	Are you wearing contact lenses?	Yes		No
16.	Are you wearing removable dental appliances?	Yes		No
17.	Do you wish to talk with the doctor privately about anything?	Yes		No
Woı	men			
18.	Are you pregnant or trying to become pregnant	Yes		No
19.	Do you have problems associated with your menstrual period?	Yes		No
20.	Are you nursing?	Yes		No
21.	Are you taking birth control pills?	Yes		No
Chief	Dental Complaint:			
been :	ify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries se answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors have made in the completion of this form.			
Patie	atient's Signature: Date:			

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history:				
Significant findi	ings from questionnaire or oral interview:			
Dental manager	ment considerations:			
Doctor's Signature	e: Date	:		
O .				
Medical Histo	ry Update			
Date	Comments	Signature		
Date	Comments	oigimuic		