

MEDICAL HISTORY FORM



Practice Administrator
 9450 E Ironwood Square Dr.
 Scottsdale, AZ 85258
 Phone: (480) 551-0581
 Fax: (480) 551-0585
 www.anewbeautifulyou.com

First Name: _____

Last Name: _____

Date: _____ / _____ / _____

Date of Birth: _____ / _____ / _____

Sex: M | F Height: _____ Weight: _____

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?	Yes		No
2.	Has there been any change in your health in the past year?	Yes		No
3.	My last physical exam was on	/	/	/
4.	Are you now under the care of a physician?	Yes		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			

1. Chest pain upon exertion?	Yes		No
2. Shortness of breath after mild exercise?	Yes		No
3. Do your ankles swell?	Yes		No
d. Allergies	Yes		No
e. Sinus trouble	Yes		No
f. Asthma or hay fever	Yes		No
g. Fainting spells or seizures	Yes		No
h. Diabetes	Yes		No
i. Hepatitis, jaundice or liver disease	Yes		No
j. Frequent or recurring mouth sores	Yes		No
k. Thyroid problems	Yes		No
l. Respiratory problems, emphysema, bronchitis, etc.	Yes		No
m. Arthritis or painful, swollen joints including jaw joint (TMJ)	Yes		No
n. Stomach ulcer or hyperacidity	Yes		No
o. Kidney trouble	Yes		No
p. Tuberculosis	Yes		No
q. Persistent cough or cough that produces blood	Yes		No
r. Persistent swollen neck glands	Yes		No
s. Low blood pressure	Yes		No
t. Epilepsy or neurological disorder	Yes		No
u. Are you taking vitamins or homeopathic remedies	Yes		No
v. Cancer	Yes		No
w. Any disease, drug or transplant operation that has depressed your immune system	Yes		No
9. Have you had abnormal bleeding?	Yes		No
a. Have you ever required a blood transfusion?	Yes		No
10. Do you have any blood disorder such as anemia?	Yes		No
11. Have you ever had treatment for a tumor or growth?	Yes		No
12. Are you allergic to or have you had a reaction to:	Yes		No
a. Local anesthetics	Yes		No
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

Women

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: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature: _____ Date: _____

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Doctor's Signature: _____ Date: _____

Medical History Update

Date	Comments	Signature