

AZ FAMILY DENTISTRY

Name: _____

Date of Birth: _____

Date: _____

Medical Information

Mark yes or no if you have or have had any of the following:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medications	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies or hives	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I Type II	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness / Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints (hips, etc)	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema / Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease / Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Redux / Fen-Phen	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting / Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic / Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Severe Gain / Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker / Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy/ Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sub-acute bacterial Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (A, B, C, D, E)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High / Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>			

Are you taking any Bisphosphonates? Such as Actonel / Fosamax / Aredia / Zometa YES OR NO

Do you have or have you had any diseases, conditions, or problems not listed? If so please list: _____

Do you smoke or chew tobacco? If yes, how much per day? _____

FOR WOMEN ONLY

	YES	NO		YES	NO
Is there any possibility of pregnancy? <input type="checkbox"/> <input type="checkbox"/> What month? _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing? <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Are you taking birth control? <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you having pain or discomfort at this time? YES NO

Have you been a patient in the hospital during the past two years? YES NO

Have you been under the care of a medical doctor or been hospitalized? YES NO

Physician's Name _____ Phone _____

Address _____

Have you had any previous surgeries? YES NO

Procedures & dates _____

Have you had any history of drug abuse or addiction? YES NO

Are you now taking any medications or drugs? YES NO

If yes, please list: _____

Are you sensitive or allergic to any medications or anesthetics? YES NO

If yes, please list: _____

Have you had any problems with anesthesia? YES NO

Dental History

	YES	NO		YES	NO
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold liquids/food?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any orthodontic work?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores/lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck, or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever experienced the following: (please circle)		
Do you floss your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Clicking, Pain (ear, side of face, joint), Difficulty in opening/closing, Difficulty chewing		

Patient Signature: _____

Doctor's Signature: _____