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	○	○

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	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

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	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: ____

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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: ____________

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