MEDICAL HISTORY FORM

ESTETICA

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

Firnt 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

Estetica Cosmetic and Reconstructive Surgery of Scottsdsale
9450 E Ironwood Square Dr., Scottsdale, AZ 85258
Phone: (480) 551-0581 | Fax: (480) 551-0585

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: _____

Estetica Cosmetic and Reconstructive Surgery of Scottsdsale
9450 E Ironwood Square Dr., Scottsdale, AZ 85258
Phone: (480) 551-0581 | Fax: (480) 551-0585

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

Estetica Cosmetic and Reconstructive Surgery of Scottsdsale
9450 E Ironwood Square Dr., Scottsdale, AZ 85258
Phone: (480) 551-0581 | Fax: (480) 551-0585