Sunny Dental Center Medical History Form

Name: _____ DOB: _____ Sex: _____ SSN: _____

Address_____State_____Zip_____

Ph #: _____Cell #: _____ Email: _____

Employer: _____Wk #: _____ Dental INS: _____

Phy Name: _____Ph #: _____ Date of last exam: _____

Emergency Contact_____Ph#-_____

Name of Spouse (or parent if patient is a child): _____

Pharmacy _____

Circle Yes or No. If you answer yes please explain in the line provided.

1. Have you had any illness during the last 5 years? YES NO
   Explain: _____
2. Have you been under a Physician's care in the last 5 years? YES NO
   Explain: _____
3. Have you been hospitalized in the last 5 years? YES NO
   Explain: _____
4. Have you taken any medications in the last year? Please list them. YES NO
   Explain: _____
5. Are you taking any drugs now? Please List them. YES NO
   Explain: _____
   _____
6. Are you allergic to any drugs or medications? Are you allergic to latex? YES NO
   Explain: _____
7. Have you or any of your family had any difficulty with local anesthesia? YES NO
   Explain: _____
8. Have you ever had excessive or unusual bleeding? YES NO
   Explain: _____
9. Have you had a blood transfusion since 1975? YES NO
10. Have you ever been tested for AIDS or HIV? YES NO If yes what were the results: _____
11. Have you had recent x-rays, radiation treatment, or any unusual exposure to radiation? YES NO
    Explain: _____
12. Are you pregnant or could you be pregnant? What is your due date? _____ YES NO

DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? CIRCLE AND WRITE WHEN.

Heart Issues/CAD	Artificial Joint	Herpes	Rheumatic fever
Heart Attack	Kidney Trouble	Syphilis	Hay Fever
High BP	Stroke	Hepatitis	Jaundice
Low BP	Diabetes	HIV/AIDS	Skin Rash/ Hives
Artificial Heart Valve	Cancer	Bipolar	Fainting Spells
Cardiac Pacemaker	Seizures/Epilepsy	Asthma	Fibromyalgia
Heart Murmur	Tuberculosis	Osteo Arthritis	Rheumatoid Arthritis
COPD	Liver Disease	Anxiety	Other: _____

Do you have any other medical issues? _____

Referred By _____ Signature: _____ Date_____

BP: _____ HR: _____ Reviewed By: _____ Date: _____