Dental Care on Golf Links
8975 E. Golf Links Rd
Tucson AZ, 85730

Medical History

Patient Name _____Date of Birth_____

Name of Physician /and their specialty_____

Most recent physical examination_____Purpose_____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or unjury	☐	☐
2. an allergic reaction to:		
aspirin, ibuprofen, acetamenophen, codeine	☐	☐
penicillin	☐	☐
erythromycin	☐	☐
tetracycline	☐	☐
sulfa	☐	☐
local anesthetic	☐	☐
fluoride	☐	☐
metals (nickel, gold, silver, _____)	☐	☐
latex	☐	☐
other _____	☐	☐
3. heart problems, or cardiac stent within the last 6 months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker or implantable defibrilator	☐	☐
7. orthopedic implant (joint replacement)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR> 3.5)	☐	☐
13. emphysema, shortness, of breath, sarcoidosis	☐	☐
14. tuberculosis, measles, chicken pox	☐	☐
15. asthma	☐	☐
16. breathing of sleeping problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidnes disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high colesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c=_____)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux)	☐	☐
26. osteroporosis/osteoperia (i.e. taking bisphosphonates)	☐	☐

	YES	NO
27. arthritis	☐	☐
28. autoimmune disease	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. head or neck injuries	☐	☐
32. epilepsy, convulsions (seizures)	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34. viral infections and cold sores	☐	☐
35. any lumps or swelling in mouth?	☐	☐
36. hives, skin rash, hay fever	☐	☐
37. STI / STD / HPV	☐	☐
38. hepatitis (type_____)	☐	☐
39. HIV / AIDS	☐	☐
40. tumor, abnormal growth	☐	☐
41. radiation therapy	☐	☐
42. chemotherapy, immunosuppressive medication	☐	☐
43. emotional difficulties	☐	☐
44. psyciatric treatment	☐	☐
45. antidepressant medication	☐	☐
46. alcohol / recreational drug use	☐	☐
ARE YOU:		
47. presently being treated for any other illness	☐	☐
48. aware of a change in your health in the last 24 hours	☐	☐
(i.e. fever, chills, new cough, or diarrhea)		
49. taking medication for weight management	☐	☐
50. taking dietary supplements	☐	☐
51. often exhausted of fatigued	☐	☐
52. experiencing frequent headaches	☐	☐
53. a smoker, smoked previously or use smokeless tobacco	☐	☐
54. considered a touchy / sensitive person	☐	☐
55. often unhappy or depressed	☐	☐
56. FEMALE - taking birth control pills	☐	☐
57. FEMALE - pregnant	☐	☐
58. MALE - prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (i.e. Botox, Collagen Injections):

_____

List all medications, supplements, and/or vitiamins taken within the last two years

Drug	Purpose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient Signature_____Date_____

Doctor Signature_____Date_____

ASA _____ (1-6)