MEDICAL HISTORY

SUN DENTAL CO.

Patient Name _____ **Birth Date**_____ **Age**_____

Are you under a primary physician care now? Yes or No

Physician's Name and Address: _____

Phone Number: _____Last Visit Date: _____

Have you ever been hospitalized or had a major operation? Yes or No, If YES: _____

Have you ever had a serious head or neck injury? Yes or No, If YES: _____

Are you taking any medications, pills, or drugs? If YES, please list the name of the drug and the condition you are taking it for: _____

Women: Are you....□ Nursing? □ Taking oral contraceptives or birth control? □ Pregnant/ Trying to get pregnant?

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Sulfa Drugs □ Local Anesthetics

□ Demerol or other Narcotics □ Other Allergies? _____

Are you required to take antibiotic pre-medication prior to appointments? Yes or No

Have you ever had any serious illness not listed above? Yes or No, If YES: _____

Do you have or have you had, any of the following? (Please Check if yes)

AIDS/HIV Positive	0 Yes 0 No	Cortisone Medicine	0 Yes 0 No	Hemophilia	0 Yes 0 No	Radiation Treatments	0 Yes 0 No
Alzheimer's Disease	0 Yes 0 No	Diabetes	0 Yes 0 No	Hepatitis A	0 Yes 0 No	Recent Weight Loss	0 Yes 0 No
Anaphylaxis	0 Yes 0 No	Drug Addiction	0 Yes 0 No	Hepatitis B or C	0 Yes 0 No	Renal Dialysis	0 Yes 0 No
Anemia	0 Yes 0 No	Easily Winded	0 Yes 0 No	Herpes	0 Yes 0 No	Rheumatic Fever	0 Yes 0 No
Angina	0 Yes 0 No	Emphysema	0 Yes 0 No	High Blood Pressure	0 Yes 0 No	Rheumatism	0 Yes 0 No
Arthritis/Gout	0 Yes 0 No	Epilepsy or Seizures	0 Yes 0 No	High Cholesterol	0 Yes 0 No	Scarlet Fever	0 Yes 0 No
Artificial Heart Valve	0 Yes 0 No	Excessive Bleeding	0 Yes 0 No	Hives or Rash	0 Yes 0 No	Shingles	0 Yes 0 No
Artificial Joint	0 Yes 0 No	Excessive Thirst	0 Yes 0 No	Hypoglycemia	0 Yes 0 No	Sickle Cell Disease	0 Yes 0 No
Asthma	0 Yes 0 No	Fainting Spells/Dizziness	0 Yes 0 No	Irregular Heartbeat	0 Yes 0 No	Sinus Trouble	0 Yes 0 No
Blood Disease	0 Yes 0 No	Frequent Cough	0 Yes 0 No	Kidney Problems	0 Yes 0 No	Spina Bifida	0 Yes 0 No
Blood Transfusion	0 Yes 0 No	Frequent Diarrhea	0 Yes 0 No	Leukemia	0 Yes 0 No	Stomach Intestinal Disease	0 Yes 0 No
Breathing Problems	0 Yes 0 No	Frequent Headaches	0 Yes 0 No	Liver Disease	0 Yes 0 No	Stroke	0 Yes 0 No
Bruise Easily	0 Yes 0 No	Genital Herpes	0 Yes 0 No	Low Blood Pressure	0 Yes 0 No	Swelling of Limbs	0 Yes 0 No
Cancer	0 Yes 0 No	Glaucoma	0 Yes 0 No	Lung Disease	0 Yes 0 No	Thyroid Disease	0 Yes 0 No
Chemotherapy	0 Yes 0 No	Hay Fever	0 Yes 0 No	Mitral Valve Prolapse	0 Yes 0 No	Tonsillitis	0 Yes 0 No
Chest Pains	0 Yes 0 No	Heart Attack/Failure	0 Yes 0 No	Osteoporosis	0 Yes 0 No	Tuberculosis	0 Yes 0 No
Cold Sores/Fever Blisters	0 Yes 0 No	Heart Murmur	0 Yes 0 No	Pain in Jaw Joints	0 Yes 0 No	Tumors or Growths	0 Yes 0 No
Congenital Heart Disorder	0 yes 0 No	Heart Pacemaker	0 Yes 0 No	Parathyroid Disease	0 Yes 0 No	Ulcers	0 Yes 0 No
Convulsions	0 Yes 0 No	Heart Trouble/Disease	0 Yes 0 No	Psychiatric Care	0 Yes 0 No	Venereal Disease	0 Yes 0 No
						Yellow Jaundice	0 Yes 0 No

DENTAL HISTORY

What is the reason for today's visit? _____

Are you currently in pain? Yes or No

Please Answer Yes or No (Please Check if yes)

Are you apprehensive about dental treatment?	0 Yes 0 No	Are you able to open your mouth wide?	0 Yes 0 No
Are your teeth sensitive to hot or cold or anything else?	0 Yes 0 No	Do you wear a night guard?	0 Yes 0 No
Are your teeth sensitive to chewing?	0 Yes 0 No	Do you have TMJ/TMD disorder?	0 Yes 0 No
Do your gums bleed when you floss or brush your teeth?	0 Yes 0 No	Do you grind or clench your teeth?	0 Yes 0 No
Do your gums feel swollen or tender?	0 Yes 0 No	Have you had trauma to the jaw?	0 Yes 0 No
Have you had gum treatment?	0 Yes 0 No	Are you a habitual gum-chewer?	0 Yes 0 No
Do you use tobacco, vapor pens or E cigarettes?	0 Yes 0 No	How often do you brush and floss your teeth? Brush:	Floss:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent or Guardian **Date**