13920 West Camino Del Sol STE 11 Sun City West AZ 85375
Phone: 623-556-5442 Fax: 623-556-5443

PATIENT MEDICAL DENTAL HISTORY

Date: _____
Patient Name: _____ Birth Date: _____
Street Address: _____ City/State: _____
Zipcode: _____
Work Phone: _____ Mobile Phone: _____
Email: _____

1) Whom may we thank for referring you? Self / Name of Referring Doctor: _____
2) Reason(s) you want treatment: _____
_____

3) Your dentist's name: _____ Date of last dental exam: _____

4) Are you aware you have bone/gum disease? Yes / No
5) Are you losing more teeth over the years? Yes / No
6) Are you in good health?
7) Do you exercise and if so, how often? Yes / No
8) Do you currently smoke or use Nicotine, how much? Yes / No ____ / Day _____ Years
9) Do you currently or have in the past used alcohol or recreational drugs? Yes / No
10) Are you nursing, pregnant or could be pregnant? Yes / No
11) Do you have sleep apnea? Yes / No
12) If yes, do you use CPAP machine? Yes / No
13) Do you have insomia? Yes / No
14) Have there any changes in your health in the past 2 years? Yes / No
15) Who is your primary care physician? Phone: _____
16) Date your last physical exam?
17) Who is your specialist physician? _____ Phone: _____

18) Have you been hospitialized or needed surgical operation? Yes / No
If yes, provide reason? _____

19) Please list all prescription drugs and over the counter drugs you are taking and what they are for?
_____
_____

20) Please list any allergic reactions and drug allergies that you are aware of?
_____
_____

21) Do you have GERD/acid reflux or taking the following medications (circle on Yes / No
Omeprazole (Prilosec, Zegerid) Lansopprazole (Prevacid) Rabeprazole (Aciphex)
Pantoprazole (Protnix) Esomeprazole (Nexium) Dexlansoprazole (Kapidex)

22) Are you taking or have you ever taken bisphosphonate (aka. bone sparing drugs Yes / No
Zometa, Aredia, Bonia, Actonel, Fosamax, Didronel, Skelid, Bonefos, Reclast, Prolia
For how long? _____ When did you stop and why? _____

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23) Are you diabetic (circle one)? Yes / No
Type I Type II Most recent HbA1c score? _____ Date of recent HbA1c? _____

24) Are you taking the following medication Zoloft (Sertraline), Prozac (Fluoxetine), Celexa (Citalopram), Lexapro (Escitalopram), Paxil, Pexeva (Paroxetine), Luvox (Fluvoxamine), Oleptro (Trazodone)
Reasons? _____

25) Please circle any conditions that you have or have had in the past? **(These are important to your care)**

AIDS/HIV
Alzheimer's/Parkinson's
Anemia (Blood disease)
Angina
Arteriosclerosis / CAD
Arthritis
Artificial Joints
Asthma or Bronchitis
Atrial/Ventricular Fib
Bleed or Bruise Easily
Blood thinner / Aspirin
Cancer/Malignancy
Chest pain
Chronic Obstructive Pulmonary
Congential Heart Disease
Congestive Heart Failure
Damaged Heart Valves
Dialysis
Diarrhea / Blood in stool
Eating disorder
Emphysema / COPD
Fainting
Persistent cough
Glaucoma
Hay fever
Heart attack / T.I.A.
Heart murmur
Herpes / Cold sores
High blood pressure
Hives / Skin rash
Hyperthyroid
Hypothyroid
Immune deficiency
Kidney disease
Leukemia / Hemophilia
Liver disease / Hepatitis
Low blood sugar
Nervous disorder
Dry mouth
Osteoporosis / Osteopenia
Pacemaker / Defibrilator
Prostate problem (cancer)
Psychiatric treatment
Rheumatic fever
Rheumatic heart disease
Seizures / Epilepsy
Shortness of breath
Sinus problems
Stroke or Head Injury
Stomach problem (reflux, GERD)
Swollen ankles
Trouble with anesthetics / I.V.
Tuberculosis
Need extra pillows to sleep

26) What is your long-term dental desires/goals/wants? _____

_____

27) Do you wear partial or complete dentur Yes / No
28) Do you have issues with your partial or complete denture(s)? _____

_____

29) Pharmacy name and location? _____ Phone: _____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date _____

We sincerely thank you for trusting us with your oral health!