Southern Arizona Periodontics, P.L.C.

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MEDICAL HISTORY

PATIENT'S NAME		EXAMINING DOCTOR
Name of Medical Doctor	Phone Number	Date of Last Medical Exam

Are you allergic to or have experienced any ill effects from:

☐ PENICILLIN	☐ CODEINE	☐ ASPIRIN	☐ NITROUS OXIDE
☐ TETRACYCLINE	☐ PERCOCET	☐ IBUPROFEN	☐ LATEX
☐ ERYTHROMYCIN	☐ DEMEROL	☐ XYLOCAINE	☐ OTHER
☐ OTHER ANTIBIOTICS	☐ VALIUM	☐ CARBOCAINE	☐ NO KNOWN ALLERGIES

Have you ever had any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Heart Disease or Attack	☐	☐	Asthma	☐	☐	Anemia	☐	☐	Epilepsy or Seizures
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Fainting
☐	☐	Heart Pacemaker	☐	☐	Ulcers	☐	☐	Thyroid Disease	☐	☐	Nervous Problems
☐	☐	Angina Pectoris	☐	☐	Anorexia / Bulimia	☐	☐	Kidney Disease	☐	☐	Mental Illness
☐	☐	Stroke	☐	☐	Alcoholism	☐	☐	Hepatitis A (infectious)	☐	☐	Psychiatric Treatment
☐	☐	Mitral Valve Prolapse	☐	☐	Drug Addiction	☐	☐	Hepatitis B (serum)	☐	☐	Convulsions
☐	☐	Heart Murmur	☐	☐	Cancer	☐	☐	Hepatitis C	☐	☐	Artificial Joints (hip, knee)
☐	☐	Circulatory Problems	☐	☐	Chemo - Radiation	☐	☐	Rheumatic Fever	☐	☐	PREMED NECESSARY
☐	☐	Emphysema	☐	☐	Malignancies - Cancer	☐	☐	Venereal Disease	☐	☐	Phen-fen/Redux Usage
☐	☐	Respiratory Problems	☐	☐	Abnormal Bleeding	☐	☐	HIV Positive			Other Health Concerns:
☐	☐	Sinus Problems	☐	☐	Hemophilia	☐	☐	AIDS			______________

What medications or drugs are you taking at this time?

Are you a smoker? ☐ **NO** ☐ **YES:** ***How Many?*** ______________

Females: Are you pregnant or trying to become pregnant? ☐ **NO** ☐ **YES:** ***How Many Months?*** ______

Medical history reviewed by Dr. ______________ ***Date*** ______