Suncook Dental

Medical Information and History

Patient's Name _____ Date of Birth _____

Please complete this form for yourself or your dependant to the best of your ability. If you have any questions or concerns, please do not hesitate to ask. At Suncook Dental, we inquire about any changes in your health at each visit. We also update this form every two years.

Medical Doctor_____ **City** _____**Approx. date last seen**_____

Are you currently being treated for anything by a physician? Yes No If yes, for what?_____

_____

Are you in good health? Yes No Do you heal normally? Yes No

Women Only - Do you take Birth Control Pills? Yes No Are you Pregnant? Yes No
Are you Nursing? Yes No

Please list all allergies including allergies to medications_____

_____

Hospitalizations and dates:

_____
_____
_____
_____

Medications you are taking and reason for taking:

_____
_____
_____
_____

Do you have a history of or have you ever been treated for any of the following conditions?

Any Heart problem	Yes No	Asthma	Yes No	Office Use Only
Heart Attack	Yes No	Tuberculosis	Yes No	_____
Heart Surgery	Yes No	Respiratory Disease	Yes No	_____
High Blood Pressure	Yes No	Kidney Disease	Yes No	_____
Pacemaker	Yes No	Liver Disease or Hepatitis	Yes No	_____
Artificial Valves	Yes No	Diabetes	Yes No	_____
Mitral Valve Prolapse	Yes No	Blood Disease	Yes No	_____
Rheumatic Fever	Yes No	Venereal Disease	Yes No	_____
Stroke	Yes No	HIV - AIDS	Yes No	_____
Epilepsy or Seizures	Yes No	Cancer or Tumors	Yes No	_____
Do you Bruise Easily?	Yes No	Mental Disorder-Nervousness	Yes No	_____
Anemia	Yes No	Sleep Disorder	Yes No	_____
Glaucoma	Yes No	Drug Addiction	Yes No	_____
Artificial Joints	Yes No	Alcoholism	Yes No	_____
Arthritis	Yes No	History of smoking	Yes No	_____

Please explain any "YES" answers _____

_____

Please provide any additional pertinent information here:_____

_____

Have you been told that you need to pre-medicate for dental treatment? Yes No

Are you taking any Bisphosphonates (medication for bone density) ? Yes No

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I understand the above information is necessary to provide me or my child with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient or Parent (Guardian) Signature _____ Date_____
Reviewed by: Staff _____ and Doctor _____
Office Use Notes _____