Dental Care on Golf Links
8975 E. Golf Links Rd
Tucson AZ, 85730
(520)886-6054

Yearly Medical Form

Patient Name ____DOB__________________

Name of Physician/their specialty____

Most recent physical examination____________________________Purpose_________________________________

Pharmacy_________________________Location_________________________________Phone____________________

Emergency Contact Name_____________________________________Phone Number______________________

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 injury ☐ ☐
2. an allergic or bad reaction to any of the following: ☐ ☐
   - ☐ aspirin, ibuprofen, acetaminophen, codeine (circle)
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ Chlorhexidine (CHX)
   - ☐ metals (nickel, gold, silver, _______________)
   - ☐ latex
   - ☐ nuts
   - ☐ fruit
   - ☐ milk
   - ☐ red dye
   - ☐ 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 defibrillator ☐ ☐
7. orthopedic or soft tissue implant (e.g. joint replacement breast implant) ☐ ☐
8. heart murmur, rheumatic or scarlet fever (circle) ☐ ☐
9. high or low blood pressure (circle) ☐ ☐
10. a stroke (taking blood thinners) ☐ ☐
11. anemia or other blood disorder ☐ ☐
12. prolonged bleeding due to a slight cut (INR> 3.5) ☐ ☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis (circle) ☐ ☐
14. Chronic ear infection, tuberculosis, measles, chicken pox (circle) ☐ ☐
15. breathing problems (e.g. asthma, stuffy nose, congestion) (circle) ☐ ☐
16. sleeping problems (i.e. sleep apnea, snoring, insomnia, restless) ☐ ☐
17. kidney disease ☐ ☐
18. liver disease or jaundice ☐ ☐
19. vertigo (e.g. "the room is spinning") ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency ☐ ☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ☐ ☐
22. high cholesterol or taking statin drugs (circle) ☐ ☐
23. diabetes (HbA1c=___________) ☐ ☐
24. stomach or duodenal ulcer (circle) ☐ ☐
25. digestive disorders (i.e. celiac disease, gastric reflux, bulimia, anorexia) (circle) ☐ ☐

YES NO

26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) (circle) ☐ ☐
27. arthritis or gout (circle) ☐ ☐
28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma) (circle) ☐ ☐
29. glaucoma ☐ ☐
30. contact lenses ☐ ☐
31. head or neck injuries ☐ ☐
32. epilepsy, convulsions (seizures) ☐ ☐
33. neurologic disorders (e.g. prion disease) ☐ ☐
34. viral infections and cold sores ☐ ☐
35. any lumps or swelling in the mouth ☐ ☐
36. hives, skin rash, hay fever (circle) ☐ ☐
37. STI / STD / HPV (circle) ☐ ☐
38. hepatitis (type   ) ☐ ☐
39. HIV / AIDS ☐ ☐
40. tumor, abnormal growth ☐ ☐
41. radiation therapy ☐ ☐
42. chemotherapy, immunosuppressive medication ☐ ☐
43. emotional difficulties ☐ ☐
44. psychiatric treatment or antidepressant medication (circle) ☐ ☐
45. concentration problems or ADD/ADHD diagnosis ☐ ☐
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 or fatigued ☐ ☐
52. experiencing frequent headaches or chronic pain ☐ ☐
53. a smoker, smoked previously or use smokeless tobacco ☐ ☐
54. considered a touchy / sensitive person ☐ ☐
55. often unhappy or depressed ☐ ☐
56. taking birth control pills ☐ ☐
57. currently pregnant ☐ ☐
58. diagnosed with prostate disorder ☐ ☐

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 vitamins 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______________________________

Provider Signature____Date______________________________

ASA _________ (1-6)