

Sunrise Dental Center
Medical History Form

Patient Name: _____

Birth Date: _____

Today's Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

COVID-19 pre-screening questions:

Have you recently travelled to an area of high-risk for COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been around someone who recently travelled to a high-risk area and is also sick?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been around someone who has been known to have the COVID-19 virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been told by a health official that you may have been exposed to COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a fever recently? Or do you think you have a fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a cough? Fatigue? Body Aches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you feeling mild to moderate shortness of breath or difficulty breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have weakened immune system from a known cause?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Women: Are you....?

- Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following?

- Penicillin Codeine Acrylic Metal Latex Sulfa Drugs

Are you under a physician's care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Have you been hospitalized or had a major operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Have you ever had a serious head or neck injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Are you taking any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use controlled substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Current Health

Do you have, or have had, any of the following?

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hep. B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Press.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excess Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Press.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever had any illnesses not listed above? Yes No If yes, please explain:

To the best of my knowledge, the question 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: _____

X _____ Date: _____