SCOTTSDALE SMILE CENTER
5410 North Scottsdale Road, Suite D-500 | Paradise Valley, Arizona 85253
(480) 991-2180 | staff@scottsdalesmile.com | scottsdalesmile.com

HEALTH HISTORY

Name _____ Date of birth _____

List all medications you are currently taking, including supplements and oral contraceptives.

_____

_____

Name of Primary Care Physician: _____

Do you take antibiotics before dental treatment? ☐ No ☐ Yes

If yes, please specify which medication and why _____

Health History (please check all that apply)

Do you take medication for or have high blood pressure? ☐ No ☐ Yes

BP Today _____

Diabetes: Type I ☐ Type II ☐ None ☐

Last A1C: _____ Approx. date: _____

Are you taking blood thinners? ☐ No ☐ Yes

Please specify reason (e.g. stroke) _____

ADD/ADHD	☐ No	☐ Yes
Anxiety/Depression	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes
Asthma	☐ No	☐ Yes
Autoimmune Disease/Rheumatism	☐ No	☐ Yes

Please Specify _____

Cancer ☐ No ☐ Yes

Please specify type and date _____

Are you currently receiving or have you ever received radiation? ☐ No ☐ Yes

Congenital Heart Disease	☐ No	☐ Yes
COPD	☐ No	☐ Yes
Dementia	☐ No	☐ Yes
Epilepsy	☐ No	☐ Yes
Fainting or Dizzy Spell	☐ No	☐ Yes
Frequent Headaches	☐ No	☐ Yes
Gastric Reflux	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes
Heart Attack	☐ No	☐ Yes

Please specify date _____

Heart Valve (replacement or repair)	☐ No	☐ Yes
Hepatitis	☐ No	☐ Yes

Please specify type _____

Herpes: Oral ☐ Genital ☐	☐ No	☐ Yes
HIV/AIDS	☐ No	☐ Yes
Hypo/Hyperthyroidism	☐ No	☐ Yes
Joint Replacement?	☐ No	☐ Yes

Please specify type _____

Kidney Disease	☐ No	☐ Yes
Liver Disease	☐ No	☐ Yes
Muscle/Connective Tissue Disorder	☐ No	☐ Yes
Osteoporosis/Osteopenia	☐ No	☐ Yes
Have you ever taken bisphosphonates?	☐ No	☐ Yes
Are you pregnant? Which trimester? _____	☐ No	☐ Yes
Previous Endocarditis/Rheumatic Fever	☐ No	☐ Yes
Sleep Apnea/Snoring/Insomnia	☐ No	☐ Yes
Stroke (type and date: _____)	☐ No	☐ Yes

Allergies

Aspirin, Ibuprofen, or any other NSAIDs	☐ No	☐ Yes
Latex	☐ No	☐ Yes
Local Anesthetics	☐ No	☐ Yes
Penicillin or other Antibiotics	☐ No	☐ Yes
Other	☐ No	☐ Yes

Please Specify _____

Tobacco, Alcohol, Drugs

Do you smoke, vape, or chew tobacco products?	☐ No	☐ Yes
Do you consume alcohol?	☐ No	☐ Yes

How much/often? _____

Do you use any mood-altering or recreational drugs? ☐ No ☐ Yes

Please List _____

Patient (print name) _____ Patient Signature _____ Date _____

Doctor (print name) _____ Doctor Signature _____ Date _____