PURELY DENTAL SURGERY
www.purelydentalsurgery.com
info@purelydentalsurgery.com | office: (602) 354-5356

Medical History

Patient Name: ______________________________ Date: ____________ Sex: M / F

Date of Birth: _______________ Age: ____ Height: ___________ Weight: ______lbs.

Patient's Phone: (______) ___________________

Below info is for us to electronically send prescriptions so they will be ready to pick up on the way home after surgery.

Patient's Address: ____________________________________ City: __________ Patients Zip Code: ________

Preferred Pharmacy Name: __________________

Pharmacy Address: ____ Pharmacy Zip Code: _________

If you are completing this form for someone else, what is your relationship to the patient? __________________

1. Are you taking any prescription or non-prescription medications .... Yes No

If so, please list and explain below

Medication	Reason for using medication	Medication	Reason for using medication
1)........................		5)........................	
2)........................		6)........................	
3)........................		7)........................	
4)........................		8)........................	

2. My last physical exam was on ____
3. Are you presently under the care of a physician........................ Yes No
   If so, for what condition ____
4. Have you ever been hospitalized or had a serious illness or operation .... Yes No
   If so, please explain ____
5. Allergic reaction to any drug, food, or substance........................ Yes No
   If so, please explain cause: __________________ *& reaction:* __________________
6. Family history of anesthetic or anesthesia complications .... Yes No
   If so, please explain: ____
7. Have you had abnormal bleeding .... Yes No
8. Do you have any blood disorder such as anemia, hemophilia, sickle cell anemia, HIV .... Yes No
9. Have you ever had treatment for a tumor or cancer .... Yes No
10. Have you ever had radiation therapy to the head, neck, or jaws .... Yes No
11. Are you taking or have you ever taken Bisphosphonates medications for osteoporosis or chemotherapy such as Fosamax, Actonel, Boniva, Aredia, or Zometa .... Yes No
12. Do you have or have you had any of the following diseases, problems, or conditions
    a. Artificial joint replacement (knee, hip, shoulder, etc.) .... Yes No
    b. Congenital heart defect .... Yes No
    c. Infective endocarditis .... Yes No
    d. Damaged heart valves or artificial valves .... Yes No
    e. Cardiovascular disease, heart trouble, heart attack, or any other heart condition .... Yes No
    f. Irregular heart beat or heart murmur .... Yes No
    g. Stroke .... Yes No

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h. Ever required a blood transfusion .... Yes No
i. Issues with your spleen .... Yes No
j. High blood pressure .... Yes No
k. Low blood pressure or fainting .... Yes No
l. Asthma .... Yes No
    i. *If so, Type_______ last A1C #________ Date of last A1C____________*
m. Respiratory problems, emphysema, bronchitis, tuberculosis, etc. .... Yes No
n. Persistent cough that produces blood .... Yes No
o. Sinus trouble .... Yes No
p. Sleep apnea .... Yes No
q. Do you snore .... Yes No
r. Seizures, epilepsy, or neurological disorder .... Yes No
s. Alzheimer's or Dementia .... Yes No
t. Diabetes .... Yes No
    i. *If so, have you ever been hospitalized or gone to ER for it?______________*
u. Hepatitis, jaundice, or liver disease .... Yes No
v. Kidney trouble .... Yes No
w. Thyroid problems .... Yes No
x. Arthritis or painful, swollen joints including jaw joint (TMJ) .... Yes No
y. Osteoporosis .... Yes No
z. Stomach ulcers or hyperactivity .... Yes No
aa. Glaucoma .... Yes No

13. Have you had any serious trouble associated with previous dental treatment .... Yes No
    If so, please explain: ____
14. Do you have any other condition or disease the doctor should know about .... Yes No
    If so, please explain: ____
15. Do you have a nervous/ psychiatric condition (including depression/ anxiety) .... Yes No
    If so, please explain: ____
16. Do you smoke, vape, or use chew tobacco .... Yes No
    If so, please specify frequency and type ______________________________
17. Do you drink alcoholic beverages .... Yes No
    If so, please specify frequency and amount ____________________________
18. History of drug or substance abuse .... Yes No
    If so, please specify ____

Females:

19. Are you pregnant or trying to become pregnant .... Yes No
20. Are you nursing .... Yes No
21. Are you taking oral contraceptives/ hormonal therapy .... Yes No
22. Do you have menstrual problems .... Yes No

I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. ALL QUESTIONS I HAD ABOUT THIS FORM HAVE BEEN ANSWERED. I UNDERSTAND IT IS MY RESPONSIBILITY TO FILL OUT THE FORM CORRECTLY AND COMPLETELY.

Additional comments you would like the doctor to know:

Patient's Signature (or Legal Guardian): ______________________