Southern Arizona Periodontics, P.L.C.

Susan B. Sharp, D.D.S.

MEDICAL HISTORY

PATIENT'S NAME	EXAMINING DOCTOR

Name of Medical Doctor	Phone Number	Date of Last Medical Exam

Are you allergic to or have experienced any ill effects from:

☐ PENICILLIN	☐ CODEINE	☐ ASPIRIN	☐ NITROUS OXIDE
☐ TETRACYCLINE	☐ PERCOCET	☐ IBUPROFEN	☐ LATEX
☐ ERYTHROMYCIN	☐ DEMEROL	☐ XYLOCAINE	☐ OTHER
☐ OTHER ANTIBIOTICS	☐ VALIUM	☐ CARBOCAINE	☐ NO KNOWN ALLERGIES

Have you ever had any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Heart Disease or Attack	☐	☐	Asthma	☐	☐	Anemia	☐	☐	Epilepsy or Seizures
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Fainting
☐	☐	Heart Pacemaker	☐	☐	Ulcers	☐	☐	Thyroid Disease	☐	☐	Nervous Problems
☐	☐	Angina Pectoris	☐	☐	Anorexia / Bulimia	☐	☐	Kidney Disease	☐	☐	Mental Illness
☐	☐	Stroke	☐	☐	Alcoholism	☐	☐	Hepatitis A (infectious)	☐	☐	Psychiatric Treatment
☐	☐	Mitral Valve Prolapse	☐	☐	Drug Addiction	☐	☐	Hepatitis B (serum)	☐	☐	Convulsions
☐	☐	Heart Murmur	☐	☐	Cancer	☐	☐	Hepatitis C	☐	☐	Artificial Joints (hip, knee)
☐	☐	Circulatory Problems	☐	☐	Chemo - Radiation	☐	☐	Rheumatic Fever	☐	☐	PREMED NECESSARY
☐	☐	Emphysema	☐	☐	Malignancies - Cancer	☐	☐	Venereal Disease	☐	☐	Phen-fen/Redux Usage
☐	☐	Respiratory Problems	☐	☐	Abnormal Bleeding	☐	☐	HIV Positive	Other Health Concerns:		
☐	☐	Sinus Problems	☐	☐	Hemophilia	☐	☐	AIDS			

What medications or drugs are you taking at this time?

Are you a smoker? ☐ **NO** ☐ **YES:** ***How Many?*** _____

Females: Are you pregnant or trying to become pregnant? ☐ **NO** ☐ **YES:** ***How Many Months?*** _____

Medical history reviewed by Dr. ***Date***