Kokopelli Family & Cosmetic Dentistry

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1327 E. Chandler Blvd, Ste 105 • Phoenix, AZ 85048-6272 (480)283-0733

MedicalHistory

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the all boxes hat apply.

☐ Angina (Chest Pain)	☐ Artificial Heart Valve	☐ Heart Conditions	☐ Heart seurgery	☐ High/Low Blood Pressure
☐ Mitral Valve Prolapse	☐ Pacemaker	☐ Rhumatic Feaver	☐ Scarlet fever	☐ Stroke
☐ Chemotherapy	☐ Radiation Therapy	☐ Diabetes	☐ HepatitisA/B/C	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Thyroid Disease	☐ Ulcers (Stomach)	☐ Gastrointestinal Disease
☐ AIDS	☐ HIV Positive	☐ HPV	☐ Asthma	☐ Emphysema
☐ Reisiratory Problems	☐ Sinus Problems	☐ Sleep Apnea	☐ Tuberculosis	☐ Anemia
☐ Blood Disorders	☐ Bruise Easily	☐ Excessive Bleeding	☐ Arthritis Artividal Jonts	☐ Jaw Joint Pain
☐ Rheumatoid Arthritis	☐ Anxiety	☐ Depression	☐ Dizziness	☐ Drug/Alcohol Addiction
☐ Fainting	☐ Seizures	☐ Psychiatric Illness	☐ Allergies Seasonal	☐ Allergies to Medications
☐ Currently Pregnant	☐ Nursing			

Please explain/clarify any conditions selected above:

_____

_____

_____

Please list the Allergies to Medications here:

_____

_____

Do you require antibiotic premedication for your dental visits? If yes, please explain below: *

_____

_____

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

Have You ever in the past, or are you now currently taking any medication for Osteopenia./Osteoporosis or Bone Disease? If so, please list the medications:

_____

_____

Describe any current medical treatment, past and future surgery, or other treatment that may possibly affect your dental treatment below:

_____

_____

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Signature _____ **Date** _____

Response Date: _____