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?	☐ Yes ☐ No
Have you been around someone who recently travelled to a high-risk area and is also sick?	☐ Yes ☐ No
Have you been around someone who has been known to have the COVID-19 virus?	☐ Yes ☐ No
Have you been told by a health official that you may have been exposed to COVID-19?	☐ Yes ☐ No
Have you had a fever recently? Or do you think you have a fever?	☐ Yes ☐ No
Do you have a cough? Fatigue? Body Aches?	☐ Yes ☐ No
Are you feeling mild to moderate shortness of breath or difficulty breathing?	☐ Yes ☐ No
Do you have weakened immune system from a known cause?	☐ Yes ☐ 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?	☐ Yes ☐ No	If yes:
Have you been hospitalized or had a major operation?	☐ Yes ☐ No	If yes:
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes:
Are you taking any medications?	☐ Yes ☐ No	If yes:
Do you use tobacco?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	

Current Health

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

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