



Caren P. Hull, D.D.S.
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 (480) 947-3747

Medical History

Name: _____

Do you presently have, had or been treated for the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Operations	<input type="checkbox"/>	<input type="checkbox"/>
Aids	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HIV Virus	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Swollen Gums	<input type="checkbox"/>	<input type="checkbox"/>	Gastric Bypass	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chemo Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies-Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Clicking Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
									Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>

Do you Smoke? _____ How Much? _____

Women Only: Are you taking birth control pills? _____ Are you pregnant? _____

Have you gone through menopause? _____ Are you taking hormone replacement therapy? _____

<u>Allergies</u>	Yes	No	<u>Medications</u>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	List any medications you are currently taking - including any blood thinners (i.e. Aspirin, Vitamin E., Coumadin) or bisphosphonetes (i.e. Boniva, Fosemax, Actonel, etc.) _____ _____ _____ _____ _____
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	
Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	
Latex	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____ _____ _____ _____			Pharmacy Name: _____ Pharmacy Phone # _____

Family Physician: _____ **Phone #:** _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Date: _____ Signature: _____

Comments for Office use only: _____

Pre-Medication: _____