DR. SUNNY OKOROJI, MS, DDS, PA
MEDICAL HISTORY

NAME: ______________________________ PHONE NUMBER: ____________________
ADDRESS: ____
STREET CITY STATE ZIP
DENTAL INSURANCE CO: ____
EMPLOYER: _________________WORK NUMBER: __________CELL NO.: _____________
DATE OF BIRTH: __________ SEX: ___ SOCIAL SECURITY NUMBER: ______-_____-_________
NAME OF SPOUSE (OR PARENT, IF PATIENT IS A CHILD) ___________________________
PHYSICIAN'S NAME _______________________ PHONE NUMBER: ________________
PHYSICIAN'S ADDRESS: ____
DATE OF LAST PHYSICAL EXAMINATION: ____________________________________

CIRCLE **YES** OR **NO**

1. Have you had any illness during the last 5 years? ___________________YES ___ NO ___
   If YES, EXPLAIN ____
2. Have you been under a physician's care in the last 5 years? _____________YES ___ NO ___
   If YES, EXPLAIN ____
3. Have you been hospitalized during the last 5 years? __________________YES___ NO_____
   If YES, EXPLAIN ____
4. Have you taken any drugs or medications during the last year? __________ YES___ NO_____
   If YES, EXPLAIN ____
5. Are you taking any drugs or medications now? _____________________YES___ NO_____
   If YES, EXPLAIN ____
6. Are you allergic to any drugs or medications? ____________________ YES ___ NO ___
   If YES, EXPLAIN ____
7. Have you or any of your family had any difficulty during Local Anesthesia? YES ____NO____
   If YES, EXPLAIN ____
8. Have you ever had excessive or unusual bleeding? __________________ YES___ NO ____
   If YES, EXPLAIN ____
9. Have you had recent X-rays,radiation treatment or unusual exposure to radiation? YES___ NO__
   If YES, EXPLAIN ____
10. Are you pregnant? ____YES__ NO __
    Estimated date of delivery______________________________
11. Blood Transfusion Since1975______ If yes, have you been tested for the Aids virus ____ When? ___
12. Have you been exposed to AIDS _____ Have you been tested _______ When______ Results___

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CIRCLE) WHEN?

Rheumatic Fever	Heart Surgery	Asthma	Cough
Heart Trouble	Stroke	Hay Fever	Tuberculosis
Cardiac Pacemaker	Unusual Bleeding	Hives	Hepatitis
Heart Murmur	Arthritis	Skin Rash	Jaundice
High Blood Pressure	Rheumatism	Coronary Artery Disease	COPD
Low Blood Pressure	Syphilis	Fainting Spells	Liver Disease
Artificial Heart Valve	Artificial Joints	Seizures	Diabetes
Heart Attack	Kidney Trouble	Epilepsy	Cancer Herpes

Do you have any other medical problems?
IF YEST EXPLAIN ____
REFERRED BY: ___________________ Signature __________________ Date ________
Reviewed By: __________________