

MEDICAL HISTORY UPDATE FORM

Date _____

Name _____ Dentist's name _____

Height _____ (Feet and inches) Weight (lbs.) _____ Date of Birth _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health.

- 1. Are you in good health?..... Yes No
2. Has there been any change in your general health within the past year? Yes No
3. My last physical examination was on _____

4. Are you now under the care of a physician? Yes No If so, for what condition?

5. The name and address of your physician is: _____

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years Yes No

7. Are you taking any medicine(s), including non-prescription medicine(s)? Yes No If so, what medicine(s) are you taking?

8. Have you ever taken Aredia, Zometa, Reclast, Fosamax, Actonel, Binosto, Atelvia, or Boniva? Yes No

9. Do you have or have you had any of the following diseases or problems?

- a. Damaged or artificial heart valves, heart murmur, or rheumatic heart disease Yes No
b. Cardiovascular disease, angina, heart attack, heart trouble, stroke Yes No
c. Osteoporosis..... Yes No
d. Cancer requiring IV chemotherapy Yes No
e. Asthma or hay fever..... Yes No
f. Fainting spells or seizures..... Yes No
g. Diabetes..... Yes No
h. Hepatitis, jaundice, or liver disease Yes No
i. AIDS or HIV infection..... Yes No
j. Thyroid problems..... Yes No
k. Respiratory problems, bronchitis, etc. Yes No

- l. Sleep apnea or snoring during sleep .Yes No
m. Stomach ulcer or hyperacidity Yes No
n. Kidney trouble Yes No
o. High or Low blood pressure..... Yes No
p. Sexually transmitted disease Yes No
q. Epilepsy/other neurological disease? Yes No
r. Problems with the spleen Yes No
s. Anxiety, depression, other mood disorders... - Yes No
t. Autism or Asperger's Yes No
u. Dementia, Alzheimer's, or other mental deficiency Yes No
10. Have you had abnormal bleeding .. Yes No Or required a blood transfusion? Yes No
11. Do you have any blood disorder such as anemia? Yes No
12. Have you been treated for a tumor? Yes No
13. Do you smoke or vape? Yes No
14. Are you allergic or have you had a reaction to:
a. Local anesthetics..... Yes No
b. Penicillin or other antibiotics..... Yes No
c. Sulfa drugs..... Yes No
d. Barbiturates, sedatives, sleeping pills Yes No
e. Aspirin Yes No
f. Iodine Yes No
g. Codeine or other narcotics Yes No

Women:
15. Are you pregnant? Yes No
16. Do you have any menstrual problems? - Yes No
17. Are you nursing? Yes No
18. Are you taking birth control pills?..... Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. If your medical history is complex or if you feel you would like to provide us with additional information, it would be helpful for us if you would use the back of this form to write out a chronological narrative of your medical history

Signature of Doctor

Signature of Patient