

## MEDICAL HISTORY UPDATE

Patient Name \_\_\_\_\_

Name of Physician/and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_

What is your estimate of your general health? (a) Excellent (b) Good (c) Fair (d) Poor

- PLEASE CHECK YES TO ANY BELOW :**
- |  |          |          |
|--|----------|----------|
|  | <b>Y</b> | <b>N</b> |
|--|----------|----------|
1. hospitalization for illness or injury \_\_\_\_\_
  2. an allergic reaction to **(CIRCLE)**
    - aspirin, ibuprofen, acetaminophen, codeine \_\_\_\_\_
    - penicillin, erythromycin, tetracycline, \_\_\_\_\_
    - other antibiotic \_\_\_\_\_
    - local anesthetic \_\_\_\_\_
    - fluoride \_\_\_\_\_
    - metals (nickel, gold, silver, other) \_\_\_\_\_
    - latex \_\_\_\_\_
    - other \_\_\_\_\_
  3. heart problems or cardiac stent within last six months \_\_\_\_\_
  4. history of infective endocarditis \_\_\_\_\_
  5. artificial heart valve, repaired heart defect (PFO) \_\_\_\_\_
  6. pacemaker or implantable defibrillator \_\_\_\_\_
  7. artificial prosthesis (heart valve or joints) \_\_\_\_\_
  8. rheumatic or scarlet fever \_\_\_\_\_
  9. high or low blood pressure \_\_\_\_\_
  10. a stroke (taking blood thinners) \_\_\_\_\_
  11. anemia or other blood disorder \_\_\_\_\_
  12. prolonged bleeding due to a slight cut (INR>3.5) \_\_\_\_\_
  13. emphysema, shortness of breath, sarcoidosis \_\_\_\_\_
  14. tuberculosis, measles, chicken pox \_\_\_\_\_
  15. asthma \_\_\_\_\_
  16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) \_\_\_\_\_
  17. kidney disease \_\_\_\_\_
  18. liver disease \_\_\_\_\_
  19. jaundice \_\_\_\_\_
  20. thyroid, parathyroid disease, or calcium deficiency \_\_\_\_\_
  21. hormone deficiency \_\_\_\_\_
  22. high cholesterol or taking statin drugs \_\_\_\_\_
  23. diabetes (HbA1c: \_\_\_\_\_) \_\_\_\_\_
  24. stomach or duodenal ulcer \_\_\_\_\_
  25. digestive disorders (i.e. gastric reflux) \_\_\_\_\_

- PLEASE CHECK YES TO ANY BELOW:**
- |  |          |          |
|--|----------|----------|
|  | <b>Y</b> | <b>N</b> |
|--|----------|----------|
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) \_\_\_\_\_
  27. arthritis, rheumatoid arthritis, lupus \_\_\_\_\_
  28. glaucoma \_\_\_\_\_
  29. contact lenses \_\_\_\_\_
  30. head or neck injuries \_\_\_\_\_
  31. epilepsy, convulsions (seizures) \_\_\_\_\_
  32. neurologic disorders (ADD/ADHD, prion disease) \_\_\_\_\_
  33. viral infections and cold sores \_\_\_\_\_
  34. any lumps or swelling in the mouth \_\_\_\_\_
  35. hives, skin rash, hay fever \_\_\_\_\_
  36. STI/STD \_\_\_\_\_
  37. hepatitis (type \_\_\_\_ ) \_\_\_\_\_
  38. HIV / AIDS \_\_\_\_\_
  39. tumor, abnormal growth \_\_\_\_\_
  40. radiation therapy \_\_\_\_\_
  41. chemotherapy, immunosuppressive \_\_\_\_\_
  42. emotional problems \_\_\_\_\_
  43. psychiatric treatment \_\_\_\_\_
  44. antidepressant medication \_\_\_\_\_
  45. alcohol / street drug use \_\_\_\_\_
- ARE YOU:**
46. presently being treated for any other illness \_\_\_\_\_
  47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, diarrhea) \_\_\_\_\_
  48. taking medication for weight management (i.e. fen-phen) \_\_\_\_\_
  49. taking dietary supplements \_\_\_\_\_
  50. often exhausted or fatigued \_\_\_\_\_
  51. experiencing frequent headaches \_\_\_\_\_
  52. a smoker, smoked previously or use smokeless tobacco (If yes, how much ) \_\_\_\_\_
  53. considered a touchy person \_\_\_\_\_
  54. often unhappy or depressed \_\_\_\_\_
  55. FEMALE - taking birth control pills \_\_\_\_\_
  56. FEMALE – pregnant \_\_\_\_\_
  57. MALE – prostate disorders \_\_\_\_\_

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

**List all medications, supplements, and or vitamins taken within the last two years:**

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for additional Sheet if taking more than 6 medications

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_