MEDICAL HISTORY UPDATE

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of the 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:

Name: _____ Date of Birth: _____ Date Form Created: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of the 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:

1. Are you under a physician's care now? ◯ Yes ◯ No If yes, _____
2. Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, _____

_____

3. Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, _____
4. Are you taking any medications, pills or drugs? ◯ Yes ◯ No If yes, _____
5. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No
   If yes, _____
6. Are you on a special diet? ◯ Yes ◯ No If yes, _____
7. Do you use tobacco? ◯ Yes ◯ No If yes, _____
8. Do you use controlled sustances? ◯ Yes ◯ No If yes, _____
9. Women: Are you ◯ pregnant/trying to get pregnant ◯ Nursing
10. Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Acrylic ◯ Latex ◯ Sulfa Drugs ◯ Local Anesthetics

11. Any other allergies we should know about? _____
12. Do you have, or have you had, any of the following

◯ AIDS/HIV Positive	◯ Hemophilia	◯ Hypoglycemia	◯ Alzheimer's Disease
◯ Diabetes	◯ Hepatitis A	◯ Recent Weight Loss	◯ Excessive Bleeding
◯ Drug Addiction	◯ Anemia	◯ Hepatitis B or C	◯ High Blood Pressure
◯ Emphysema	◯ Herpes	◯ Arthritis/Gout	◯ Epilepsy or Seizures
◯ High Cholesterol	◯ Anaphylaxis	◯ Hives or Rash	◯ Radiation Treatments
◯ Thyroid Disease	◯ Asthma	◯ Osteoporosis	◯ Low Blood Pressure
◯ Blood Disease	◯ Convulsions	◯ Breathing Problems	◯ Sickle Cell Diseaase
◯ Sinus Trouble	◯ Cancer	◯ Lung Disease	◯ Cold Sores/Fever Blisters
◯ Tonsillitis	◯ Chest Pains	◯ Heart Attack/Failure	◯ Fainting Spells/Dizziness
◯ Tuberculosis	◯ Stroke	◯ Heart Murmur	◯ Tumors or Growths
◯ Heart Pacemaker	◯ Ulcers	◯ Kidney Problems	◯ Heaart Trouble/Disease
◯ Psychiatric Care			

13. Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Patient Signature Date