Medical History Update

Today's Date_____

Name_____Birthdate_____
Want to be contacted by Email? **_____@_____**
Hm phone #_____ Cell #_____ Work #_____

Yes[ ] No[ ] Are you under the care of a Medical Doctor?
Yes[ ] No[ ] Have you been hospitalized during the past 2 yrs?
Yes[ ] No[ ] Are you taking any vitamins, medications or drugs at this time?
LIST ANY MEDICATIONS YOUR TAKING & THE REASON:

_____
_____
_____
Yes[ ] No[ ] Have you taken the diet drug Phentermine/Fenfluramine/Dexfenfluramine?
Yes[ ] No[ ] Have you taken any recreational drugs in the past or currently?
Yes[ ] No[ ] Have you ever taken Fosomax or similar medications for bone density?

PHARMACY _____ Physician_____

Yes[ ] No[ ] Are you allergic to Penicillin, Local Anesthetic, Aspirin, Codeine, or any other drugs/medications? List: _____
What are the side effects of your allergic reaction? (Itching, rash, swelling, etc.) _____
_____
Yes[ ] No[ ] Have you ever had any excessive bleeding requiring special treatment?
Yes[ ] No[ ] When your walking or go up stairs, do you have to stop because of chest pain, shortness of breath, or you tire easily?
Yes[ ] No[ ] Do your ankles swell during the day?
Yes[ ] No[ ] Do you use more than two pillows to elevate your head to sleep?
Yes[ ] No[ ] Do you ever wake from sleep short of breath?
Yes[ ] No[ ]Have you lost or gained an excessive amount of weight in the last year?
Yes[ ] No[ ] Do you use any form of Tobacco?
WOMEN: Do you anticipate becoming pregnant? Yes[ ] No[ ]
Are you pregnant now? Yes[ ] No[ ]
Are you practicing birth control? Yes[ ] No[ ]

PLEASE CHECK PAST OR PRESENT MEDICAL CONDITIONS BELOW:
Yes[ ] No[ ] Heart Failure_____
Yes[ ] No[ ] Heart Disease_____
Yes[ ] No[ ] Heart Murmur_____
Yes[ ] No[ ] Angina Pectoris_____
Yes[ ] No[ ] High Blood Pressure_____
Yes[ ] No[ ] Rheumatic Fever_____
Yes[ ] No[ ] Scarlet Fever_____
Yes[ ] No[ ] Congenital Heart Valve_____
Yes[ ] No[ ] Artificial Heart Valves_____

CONTINUED >>>>>

Yes[ ] No[ ] Heart Pacemaker_____
Yes[ ] No[ ] Heart Surgery (Bypass or Stint)_____
Yes[ ] No[ ]Artificial Joint_____
Yes[ ] No[ ]Implants _____
Yes[ ] No[ ] Anemia _____
Yes[ ] No[ ] Stroke _____
Yes[ ] No[ ] Kidney Disease _____
Yes[ ] No[ ] Alcoholic/Drug Abuse _____
Yes[ ] No[ ] Thyroid Disease _____
Yes[ ] No[ ] Chemotherapy _____
Yes[ ] No[ ] Cancer _____
Yes[ ] No[ ] Blood Disease _____
Yes[ ] No[ ] Arthritis/Rheumatism _____
Yes[ ] No[ ] Cortisone Medication _____
Yes[ ] No[ ] Glaucoma _____
Yes[ ] No[ ] Chronic Cough _____
Yes[ ] No[ ]Tuberculosis _____
Yes[ ] No[ ] Asthma _____
Yes[ ] No[ ] Sinus Trouble _____
Yes[ ] No[ ] Allergies/Hives _____
Yes[ ] No[ ] Ulcers _____
Yes[ ] No[ ] Emphysema _____
Yes[ ] No[ ] HIV/AIDS _____
Yes[ ] No[ ] Hepatitis Type _____
Yes[ ] No[ ] Liver Disease _____
Yes[ ] No[ ] Yellow Jaundice _____
Yes[ ] No[ ] Blood Transfusion _____
Yes[ ] No[ ] Cold Sores _____
Yes[ ] No[ ] Epilepsy or Seizures _____
Yes[ ] No[ ] Diabetes _____
Yes[ ] No[ ] Fainting/Dizzy Spells _____
Yes[ ] No[ ] Nervousness _____
Yes[ ] No[ ] Psychiatric Treatment _____
Yes[ ] No[ ] Bruise Easily _____
Yes[ ] No[ ] Frequent Headaches _____
Yes[ ] No[ ] Please list any other conditions not listed: _____
_____

All information is confidential, to the best of my knowledge all of the preceding answers are true and correct. If I ever have any changes in my health or medication, I will inform the Dentist at the next appointment.

Signature of Patient, Parent or Guardian

_____**Date**_____
_____**Update**_____
_____**Update**_____
_____**Update**_____