# UPDATED MEDICAL HISTORY

Patient Name: _____ Birthdate: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: Email_____

1. Have you been seen in the Hospital/ER during the past two years?..... ❑ YES ❑ NO

   If yes, please specify: _____

   _____

   Please list preferred Pharmacy:_____ _____ _____ ___

2. Have you been under the care of a medical doctor in the past two years other than a routine physical?.... ❑ YES ❑ NO

3. Are you currently taking any medications or drugs?..... ❑ YES ❑ NO

   If yes, please list_____

   _____

   _____

4. Have you ever taken any of the following bisphosphonates such as? ❑ Fosamax ❑ Actonol ❑ Reclast ❑ Other_____

5. Are you aware of being allergic to any medications, latex, or substances?..... ❑ YES ❑ NO

   If yes, please list _____

6. Have you ever been told that you require a premedication before a dental visit……..❑ YES ❑ NO

7. Please check if you have ever used any of the following substances? ❑ Tobacco/Frequency_____ ❑ Alcohol/Frequency_____

8. Check any of the following which you have had or have at present:

- ☐ Heart Murmur
- ☐ Blood Thinner/Aspirin
- ☐ Heart Attack - When?
- ☐ Artificial Joints - When?
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Emphysema
- ☐ Asthma
- ☐ Diabetes
- ☐ A.I.D.S.
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Hepatitis C
- ☐ H.I.V.
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Chemotherapy/Radiation
- ☐ Drug Addiction
- ☐ Kidney Trouble
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Treatment
- ☐ Tuberculosis
  - persistent cough
  - bloody sputum
  - anorexia
  - fever
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Arthritis
- ☐ Bruise Easily
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Liver Disease
- ☐ Seizures
- ☐ Sickle Cell Diseases
- ☐ Sinus Trouble
- ☐ Stroke - When?
- ☐ Venereal Disease
- ☐ Acid Reflux

FOR WOMEN ONLY:

Are you pregnant? ❑ YES ❑ NO If yes, what is your due date? _____
Are you taking birth control pills? ❑ YES ❑ NO
Are you nursing? ❑ YES ❑ NO

9. Do you have any disease, condition or problem not listed? If yes, please list _____

   _____

   _____

10. Additional Notes:_____

    _____

    _____

Patient Signature: _____ Date: _____ / _____ / _____

Parent/Responsible Party: _____ Relation to Patient:_____