MEDICAL HISTORY UPDATE

Patient Name: ____ Date: __________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Surgeries, health issues, and medications you take could have an important interrelationship with the dentistry you will receive. Please answer all questions to the best of your knowledge.

Physician's Name: ____ Phone#: __________________________________

Are you allergic/had an adverse reaction to any of the following:

Local Anesthetics (Novocaine, etc) . . . . ☐ **Yes** ☐ **No**
Codeine/Narcotics . . . . ☐ **Yes** ☐ **No**
Penicillin . . . . ☐ **Yes** ☐ **No**
Sulfa Drugs or Other Antibiotics . . . . ☐ **Yes** ☐ **No**
Latex . . . . ☐ **Yes** ☐ **No**
Metals/Nickels/Plastics . . . . ☐ **Yes** ☐ **No**
Ibuprofen/Advil/Aleve/NSAIDS . . . . ☐ **Yes** ☐ **No**
Aspirin . . . . ☐ **Yes** ☐ **No**
Other (Please specify): ____

Please list all **medications** you are currently taking, including over the counter meds and vitamins. List additional medications in email if needed.

Medication/Dosage: Condition:

____ ______________________________________
____ ______________________________________
____ ______________________________________
____ ______________________________________
____ ______________________________________
____ ______________________________________

Do you have or have you ever had any of the following:

Heart attack, Heart Disease . . . . **Yes** **No**
Congenital Heart Disease. . . . . **Yes** **No**
Angina Pectoris . . . . **Yes** **No**
Stroke/Arteriosclerosis . . . . **Yes** **No**
High/low blood pressure . . . . **Yes** **No**
Pacemaker . . . . **Yes** **No**
Artificial or replacement valves . . . . **Yes** **No**
Osteoporosis. . . . . **Yes** **No**
Thyroid disease . . . . **Yes** **No**
Anemia . . . . **Yes** **No**
Blood Thinners. . . . . **Yes** **No**
Presence of a stent related to coagulation therapy. .. . **Yes** **No**
Glaucoma . . . . **Yes** **No**
Asthma . . . . **Yes** **No**
Hay fever, sinus troubles, allergies . . . . **Yes** **No**
Hives or skin rash . . . . **Yes** **No**
Epilepsy, fainting spells or seizures . . . . **Yes** **No**
Diabetes . . . . **Yes** **No**
Hepatitis, jaundice, or liver disease . . . . **Yes** **No**
Arthritis or inflammatory rheumatism . . . . **Yes** **No**
Artificial or replacement joints, prosthetic pins . . . . **Yes** **No**
Ulcers or stomach disorders (colitis) . . . . **Yes** **No**
GERD . . . . **Yes** **No**
Kidney trouble . . . . **Yes** **No**
Tuberculosis . . . . **Yes** **No**
Immune system disorders (including AIDS,HIV, ARC) . . **Yes** **No**
Venereal Disease, Herpes . . . . **Yes** **No**

Have you been hospitalized or had *any* surgeries in the last two years?.. . . . . **Yes** **No**
Explain____
Have you had surgery, radiation or chemotherapy for a tumor, growth, cancer or other condition? . . . .
Are you currently being treated with Biophosphonates such as Fosamax, Boniva, or Actonel?. . . . . **Yes** **No**
Do you use tobacco or alcohol products?. . . . . **Yes** **No**
If so, how much per day and what? ____ **Yes** **No**
Do you have any disease, condition, or problem not listed above?. . . . .
Explain____ **Yes** **No**

FOR WOMEN ONLY

Are you pregnant? . . . . **Yes** **No**
Are you taking birth control or hormone therapy? . . . . **Yes** **No**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the Dentist at the next appointment.

____ ____
Patient Initials Date Dentist Signature Date

Please email completed form to office@wjscottdds.com