PRESTIGE

Family & Cosmetic Dentistry

MEDICAL HEALTH HISTORY UPDATE

Patient's Name: _____

Have you recently developed any of the following?

Heart Problems

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blood pressure problem
- ☐ Heart murmur
- ☐ Heart valve problem
- ☐ Taking heart medication
- ☐ Rheumatic fever
- ☐ Pacemaker
- ☐ Artificial heart valve

Blood Problems

- ☐ Easy bruising
- ☐ Frequent nosebleeds
- ☐ Abnormal bleeding
- ☐ Blood disease (anemia)
- ☐ Ever require a blood transfusion?

Allergies

- ☐ Hay fever
- ☐ Sinus problems
- ☐ Skin rashes
- ☐ Taking allergy medication
- ☐ Asthma

Intestinal Problems

- ☐ Ulcer(s)
- ☐ Significant weight change
- ☐ Special diet
- ☐ Constipation/Diarrhea
- ☐ Kidney or bladder problems

Have you recently developed any of the following?

Bone or Joint Problems

- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Joint replacement (e.g., total hip, pins, or implants)
- ☐ Fainting Spells, Seizures, or Epilepsy
- ☐ Stroke(s)
- ☐ Frequent or severe headaches
- ☐ Thyroid problems
- ☐ Persistent cough or swollen glands
- ☐ PREMEDICATION REQUIRED?
- ☐ Cancer/Tumor

Diabetes

- ☐ Urinate more than 6 times a day
- ☐ Thirsty or mouth is dry much of the time
- ☐ Family history of diabetes
- ☐ Tuberculosis or other respiratory disease
- ☐ Do you drink alcohol?
  If so, how much? _____
- ☐ Do you smoke?
  If so, how much? _____
- ☐ Hepatitis, jaundice, or liver trouble
- ☐ Herpes or other STD
- ☐ HIV-positive/AIDS
- ☐ Glaucoma
- ☐ Do you wear contact lenses?
- ☐ History of head injury?
- ☐ Epilepsy or other neurological disease?
- ☐ History of alcohol or drug abuse?
- ☐ Other: _____

Have you taken any of the following in the past year?

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (e.g., Coumadin)
- ☐ High blood pressure medicine
- ☐ Tranquilizers
- ☐ Insulin, Orinase, or similar drug
- ☐ Aspirin
- ☐ Digitalis or drugs for heart trouble
- ☐ Nitroglycerin
- ☐ Cortisone (steroids)
- ☐ Natural remedies
- ☐ Nonprescription drug/supplements
- ☐ Other: _____

Have you had an allergic or otherwise adverse reaction to any of the following in the past year?

- ☐ Local anesthetics (e.g., Novocaine)
- ☐ Antibiotics (e.g., Penicillin)
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin, Acetaminophen, or Ibuprofen
- ☐ Codeine, Demerol, or other narcotics
- ☐ Reaction to metals
- ☐ Latex or rubber dam
- ☐ Other: _____

Do any of the following statements apply?

- ☐ Taking contraceptives / other hormones
- ☐ I'm currently pregnant
- ☐ I'm nursing a child
- ☐ I've reached menopause

Name of patient or responsible party:_____ Relationship to patient: _____

_____

Signature of patient or responisble party Date

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