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MEDICAL HISTORY UPDATE FORM

Name Last First Middle Date

Ht Wt Date of Birth / / Dentist's Name

If you are completing this form for another person, what is your relationship to that person?

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health.

- 1. Are you in good health? Yes No
2. Has there been any change in your general health within the past year? Yes No
3. My last physical examination was on
4. Are you now under the care of a physician? Yes No
5. The name and address of your physician is:
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
7. Are you taking any medicine(s), including non-prescription medicine(s)? Yes No
8. Have you ever taken Aredia, Zometa, Fosamax, Actonel, or Boniva? Yes No
9. Do you have or have you had any of the following diseases or problems?
a. Damaged or artificial heart valves, heart murmur, or rheumatic heart disease
b. Cardiovascular disease, angina, heart attack, heart trouble, stroke
c. Osteoporosis
d. Cancer requiring IV chemotherapy
e. Asthma or hay fever
f. Fainting spells or seizures
g. Diabetes
h. Hepatitis, jaundice, or liver disease
i. AIDS or HIV infection
j. Thyroid problems
k. Respiratory problems, bronchitis, etc.
l. Sleep apnea or snoring during sleep
m. Stomach ulcer or hyperacidity
n. Kidney trouble
o. High or Low blood pressure
p. Sexually transmitted disease
q. Epilepsy/other neurological disease?
r. Problems with the spleen
10. Have you had abnormal bleeding? Or required a blood transfusion?
11. Do you have any blood disorder such as anemia?
12. Have you been treated for a tumor?
13. Are you allergic or have you had a reaction to:
a. Local anesthetics
b. Penicillin or other antibiotics
c. Sulfa drugs
d. Barbiturates, sedatives, sleeping pills
e. Aspirin
f. Iodine
g. Codeine or other narcotics
h. Other
14. Are you pregnant?
15. Do you have any menstrual problems?
16. Are you nursing?
17. Are you taking birth control pills?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. If your medical history is complex or if you feel you would like to provide us with additional information, it would be helpful for us if you would use the back of this form to write out a chronological narrative of your medical history.

Signature of Dr. De Simone

Signature of Patient (or Patient's Guardian)

** RETURN THIS COMPLETED FORM TO YOUR DENTIST PRIOR TO SURGERY **