AUSTIN PERIO HEALTH
MEDICAL HISTORY UPDATE

TODAY'S DATE: _____

PATIENT INFORMATION								
FIRST:		**MIDDLE:**		**LAST NAME:**		**DOB:**		
ADDRESS:		CITY:		STATE:		ZIP:		
EMAIL ADDRESS:		CELL PHONE:		HOME PHONE:				
Who is your General Dentist (DDS)?		Phone:						
Pharmacy Name:		Pharmacy Phone:		Pharmacy Address:				
IN CASE OF EMERGENCY, PLEASE CONTACT: Name:		Phone:		Relationship:				

PRIMARY DENTAL INSURANCE (POLICY HOLDER) - (*Please list Name as it appears on your Dental Insurance*)								
FIRST:		MIDDLE:		LAST NAME:		DOB:		
INSURANCE COMPANY:		POLICY/GROUP #		MEMBER ID/SS#:				
CLAIMS ADDRESS:		CITY:		STATE:		ZIP:		

General Health Questions:

Does your regular doctor or any specialist that you see require you to take a pre-med antibiotic prior to dental treatment? ☐ Yes ☐ No
If yes, Prescribing doctor's name: _____ *Ph:* _____ *For what condition:* _____

Are you taking Anticoagulants/Blood thinners (such as Coumadin (Warfarin), Plavix, Eliquis, Xarelto, Pradaxa, Aspirin)? ☐ Yes ☐ No
If yes, what kind and how often? _____

Are you taking, or ever taken any bisphosphonate/bone density medications or RANKL inhibitors for osteoporosis/osteopenia such as Fosamax, Boniva, Actonel, Evista, Zometa/Reclast, Prolia or others in the past 12 years? ☐ Yes ☐ No
If yes, what kind and how often? _____

Are you taking, or ever taken **tranquilizers**, **sleeping pills**, **anti-depressants** and/or **muscle relaxers** on a regular basis? ☐ Yes ☐ No
If yes, what kind and how often? _____

Are you taking, or ever taken **narcotics, pain killers/pain management medication** or **stimulants** on a regular basis? ☐ Yes ☐ No
If yes, what kind and how often? _____

Please list any other medications/pills/drugs that you are taking at this time: _____

_____

Have there been any changes to your general health in the past year? ☐ Yes ☐ No
If yes, please explain: _____

In the past two years, have you been under a physician's care other than routine checkups? ☐ Yes ☐ No
If yes, please explain: _____

Have you been hospitalized or had a major operation in the past five (5) years? ☐ Yes ☐ No
If yes, please explain: _____

Do you have shortness of breath after climbing one flight of stairs? ☐ Yes ☐ No

Have you, or anyone in your family ever had an adverse reaction to sedation medication, local or general anesthesia? ☐ Yes ☐ No
If yes, please explain: _____

Do you consider yourself in good health at this time? ☐ Yes ☐ No

Women Only: ☐ Pregnant ☐ Nursing ☐ Trying to get pregnant ☐ Taking oral contraceptives ☐ Menopause ☐ Hysterectomy ☐ Taking hormone medication

* *Women note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist regarding additional methods of birth control.*

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions on the next page:

MEDICAL HISTORY:

HEIGHT: _____ WEIGHT: _____ Gender: ☐ Male ☐ Female

Primary Care Physician's Name: _____ Phone: _____ Date of last physical exam? _____

Medical Allergies - Are you allergic to any of the following? (*Please check all that apply*)

Pain Medications: ☐ Aspirin ☐ Ibuprofen(Advil) ☐ Acetaminophen (Tylenol) ☐ Vicodin/Hydrocodone ☐ Tramadol ☐ Codeine ☐ Demerol

Anxiety Medications: ☐ Alprazolam (Xanax) ☐ Diazepam (Valium) ☐ Lorazepam (Ativan) ☐ Halcion ☐ Nubain ☐ Versed

Antibiotics: ☐ Penicillin ☐ Erythromycin ☐ Azithromycin ☐ Clindamycin (Cleocin) ☐ Cephalexin (Keflex) ☐ Ciprofloxacin (Cipro) ☐ Tetracycline ☐ Doxycycline

Other: ☐ Latex ☐ Iodine ☐ Sulfa Drugs ☐ Sulfites ☐ Metal ☐ Acrylic ☐ Eggs/Yolk ☐ Soy

Local Anesthetics: ☐ Lidocaine ☐ Marcaine ☐ Carbocaine ☐ Epinephrine

Other Allergies (not listed above): _____

MEDICAL CONDITIONS: Do you have, or have you had, any of the following:

HEART/CARDIAC					
Angina/Chest Pain	☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No	Cardiac Pacemaker	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Congestive Heart Failure	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Heart Attack/MI	☐ Yes ☐ No	Heart Murmur/Irregular Heartbeat	☐ Yes ☐ No
Athersclerosis	☐ Yes ☐ No	Heart Surgery	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
BLOOD / AUTOIMMUNE					
AIDS	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Difficulty Clotting	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Hepatitis A	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No	Hepatitis C	☐ Yes ☐ No
Hypoglycemia	☐ Yes ☐ No	Immunocompromised	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Sickle Cell Disease	☐ Yes ☐ No	Sjogren's syndrome	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Radiation/Chemotherapy	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No		
BONE / SKIN					
Artificial Joint (Hip/Knee/Other)	☐ Yes ☐ No	Arthritis/Gout	☐ Yes ☐ No	Osteopenia	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Osteonecrosis	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Hives or Rash	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No	Swelling of Limbs/Ankles	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No	Excessive Thirst/Dry Mouth	☐ Yes ☐ No
HEAD / NECK / BEHAVIORAL					
Alzheimer's Disease	☐ Yes ☐ No	Memory issues	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Parathyroid Disease	☐ Yes ☐ No	Glaucoma/Eye Disease	☐ Yes ☐ No	Head Injury	☐ Yes ☐ No
Neck Injury	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No
Epilepsy/Seizures/Convulsions	☐ Yes ☐ No				
LUNGS / SINUS					
COPD/Breathing Problems	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Frequent Cough/Bronchitis	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
LIVER / KIDNEYS / INTESTINAL					
Kidney Disease/Problems	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No	Liver Disease/Jaundice	☐ Yes ☐ No
Stomach Ulcers/Acid Reflux	☐ Yes ☐ No	Frequent Diarrhea/IBS	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
SUBSTANCES					
Drug Addiction	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No	Smoke/Chew Tobacco/Vape	☐ Yes ☐ No
History of drug abuse	☐ Yes ☐ No	History of Alcohol Abuse	☐ Yes ☐ No	Prolonged Steroid Use	☐ Yes ☐ No

* *IF YOU CHOSE EPILEPSY/SEIZURES/CONVULSIONS, are they*: ☐ Frequent ☐ Infrequent Controlled with medication? ☐ Yes ☐ No

* *IF YOU CHOSE ASTHMA, is it currently being controlled with medications/inhaler*? ☐ Yes ☐ No

* IF YOU CHOSE DIABETES, *is it:* ☐ Borderline/Diet Controlled ☐ Type 1 ☐ Type 2 ☐ Insulin Dependent ☐ Well-controlled ☐ Family History? ☐ ☐ Most recent A1C level? _____ Date? _____

Any serious Illness, disease or medical problem not mentioned above? ☐ Yes ☐ No

If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

I certify that I have read and I understand the questions 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 doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

PRINT NAME: _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____ DATE: _____

DOCTOR'S SIGNATURE: _____ DATE: _____