

**AUSTIN PERIO HEALTH**  
**MEDICAL HISTORY UPDATE**

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Who is your current General Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

*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.*

**MEDICAL HISTORY:** HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Who is your **Primary Care Physician**: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Phone: \_\_\_\_\_

What is the date of your last complete medical/physical exam? \_\_\_\_\_

What is your preferred **Pharmacy, address and phone #**? \_\_\_\_\_

In case of emergency, please contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Medical Allergies:**

Are you allergic to any of the following?

- |   |   |                                    |  |                               |   |
|---|---|------------------------------------|--|-------------------------------|---|
| <input type="radio"/> Aspirin               | <input type="radio"/> Penicillin          | <input type="radio"/> Codeine      | <input type="radio"/> Local Anesthetics  | <input type="radio"/> Versed  | <input type="radio"/> Latex                               |
| <input type="radio"/> Vicodin/Hydrocodone   | <input type="radio"/> Clindamycin/Cleocin | <input type="radio"/> Sulfa Drugs  | <input type="radio"/> General Anesthesia | <input type="radio"/> Demerol | <input type="radio"/> Acrylic                             |
| <input type="radio"/> Ibuprofen/Advil       | <input type="radio"/> Erythromycin        | <input type="radio"/> Tetracycline | <input type="radio"/> Nubain             | <input type="radio"/> Metal   | <input type="radio"/> Sulfites                            |
| <input type="radio"/> Tylenol/Acetaminophen | <input type="radio"/> Xanax/Valium/Ativan | <input type="radio"/> Keflex       | <input type="radio"/> Halcion            | <input type="radio"/> Iodine  | <input type="radio"/> Eggs/Yolk <input type="radio"/> Soy |

Please list any other medications/antibiotics that you are allergic to: 1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**General 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

Prescribing doctor's name: \_\_\_\_\_ Ph: \_\_\_\_\_ For what condition: \_\_\_\_\_

Are you taking **Anticoagulants/Blood thinners** (such as Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)? ☐ Yes ☐ No

If yes, what kind and how often? \_\_\_\_\_

Are you taking, or have you ever taken any medications for **osteoporosis/osteopenia, bone-related issues, bone density medications, RANKL inhibitors or bisphosphonates** such as Denosumab, Fosamax, Boniva, Actonel, Evista, Skelid, Didronel, Ostac, Zometa, Aredia, Reclast, Prolia, Bonefos, Xgeva, (Other) \_\_\_\_\_ in the past 12 years? ☐ Yes ☐ No

Are you taking, or have you 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 have you ever taken **narcotics, pain killers/pain management medication, and/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: 1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

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/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐ Hysterectomy? ☐ Menopause? ☐ 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.

**MEDICAL CONDITIONS:**

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

HEART/CARDIAC		
Angina/Chest Pain	<input type="radio"/> Yes	<input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes	<input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes	<input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes	<input type="radio"/> No
Congestive Heart Failure	<input type="radio"/> Yes	<input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No
High Cholesterol	<input type="radio"/> Yes	<input type="radio"/> No
Heart Attack/MI	<input type="radio"/> Yes	<input type="radio"/> No
Heart Murmur/Irregular Heartbeat	<input type="radio"/> Yes	<input type="radio"/> No
Heart Surgery	<input type="radio"/> Yes	<input type="radio"/> No
Heart Disease	<input type="radio"/> Yes	<input type="radio"/> No
Low Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No
Mitral Valve Prolapse	<input type="radio"/> Yes	<input type="radio"/> No
Stroke	<input type="radio"/> Yes	<input type="radio"/> No

HEAD/NECK/BEHAVIORAL		
Alzheimer's Disease	<input type="radio"/> Yes	<input type="radio"/> No
Anxiety	<input type="radio"/> Yes	<input type="radio"/> No
Depression	<input type="radio"/> Yes	<input type="radio"/> No
Psychiatric Care	<input type="radio"/> Yes	<input type="radio"/> No
Epilepsy/Seizures/Convulsions *	<input type="radio"/> Yes	<input type="radio"/> No
Thyroid/Parathyroid Disease	<input type="radio"/> Yes	<input type="radio"/> No
Glaucoma/Eye Disease	<input type="radio"/> Yes	<input type="radio"/> No
Head/Neck Injury	<input type="radio"/> Yes	<input type="radio"/> No
Fainting Spells/Dizziness	<input type="radio"/> Yes	<input type="radio"/> No
Frequent Headaches	<input type="radio"/> Yes	<input type="radio"/> No

BLOOD/AUTOIMMUNE		
AIDS/HIV Positive	<input type="radio"/> Yes	<input type="radio"/> No
Anemia	<input type="radio"/> Yes	<input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes	<input type="radio"/> No
Difficulty Clotting/Excessive Bleeding	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes *	<input type="radio"/> Yes	<input type="radio"/> No
Hemophilia	<input type="radio"/> Yes	<input type="radio"/> No
Hepatitis (A, B, C)	<input type="radio"/> Yes	<input type="radio"/> No
Hypoglycemia (low blood sugar)	<input type="radio"/> Yes	<input type="radio"/> No
Immunocompromised	<input type="radio"/> Yes	<input type="radio"/> No
Leukemia	<input type="radio"/> Yes	<input type="radio"/> No
Sickle Cell Disease	<input type="radio"/> Yes	<input type="radio"/> No
Sjogren's syndrome	<input type="radio"/> Yes	<input type="radio"/> No
Cancer/Radiation/Chemotherapy	<input type="radio"/> Yes	<input type="radio"/> No
Tumors or Growths	<input type="radio"/> Yes	<input type="radio"/> No

LUNGS/SINUS		
Asthma *	<input type="radio"/> Yes	<input type="radio"/> No
COPD or Lung/Breathing Problems	<input type="radio"/> Yes	<input type="radio"/> No
Emphysema	<input type="radio"/> Yes	<input type="radio"/> No
Frequent Cough/Bronchitis	<input type="radio"/> Yes	<input type="radio"/> No
Tuberculosis	<input type="radio"/> Yes	<input type="radio"/> No
Sinus Problems	<input type="radio"/> Yes	<input type="radio"/> No
Sleep Apnea/CPAP/Snoring	<input type="radio"/> Yes	<input type="radio"/> No
Seasonal Allergies	<input type="radio"/> Yes	<input type="radio"/> No

BONE/SKIN		
Arthritis/Gout	<input type="radio"/> Yes	<input type="radio"/> No
Artificial Joint (Hip/Knee/Other)	<input type="radio"/> Yes	<input type="radio"/> No
Osteopenia/Osteoporosis	<input type="radio"/> Yes	<input type="radio"/> No
Osteonecrosis	<input type="radio"/> Yes	<input type="radio"/> No
Shingles	<input type="radio"/> Yes	<input type="radio"/> No
Hives or Rash	<input type="radio"/> Yes	<input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes	<input type="radio"/> No
Swelling of Limbs/Ankles	<input type="radio"/> Yes	<input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes	<input type="radio"/> No
Recent Weight Loss	<input type="radio"/> Yes	<input type="radio"/> No
Excessive Thirst/Dry Mouth	<input type="radio"/> Yes	<input type="radio"/> No

LIVER/KIDNEYS/INTESTINAL		
Kidney Disease/Problems	<input type="radio"/> Yes	<input type="radio"/> No
Renal Dialysis	<input type="radio"/> Yes	<input type="radio"/> No
Liver Disease/Jaundice	<input type="radio"/> Yes	<input type="radio"/> No
Frequent Diarrhea/IBS/Incontinence	<input type="radio"/> Yes	<input type="radio"/> No
Stomach Ulcers/Acid Reflux	<input type="radio"/> Yes	<input type="radio"/> No

SUBSTANCES		
Drug Addiction/History of abuse	<input type="radio"/> Yes	<input type="radio"/> No
History of Alcohol Abuse	<input type="radio"/> Yes	<input type="radio"/> No
Smoke/Chew Tobacco or Vape	<input type="radio"/> Yes	<input type="radio"/> No
Prolonged Steroid Use	<input type="radio"/> Yes	<input type="radio"/> 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?  
What was your 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: \_\_\_\_\_