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MEDICAL HISTORY UPDATE FORM

Name_____ Date_____
Last First Middle

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
   If so, for what condition? _____
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. Do you have any surgical/anesthesia history? . Yes No
   If yes, explain_____
8. Does your family have any surgical/anesthesia history?
   If yes, explain_____ Yes No
9. Are you taking any medicine(s), including non-prescription medicine(s)? ..... Yes No
   If so, what medicine(s) are you taking?_____
   _____
   _____
   _____
10. Have you ever taken Aredia, Zometa, Reclast, Fosamax, Actonel, Binosto, Atelvia, or Boniva? ..... Yes No
11. 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 ..... Yes No
    b. Cardiovascular disease, angina, heart attack, heart trouble, stroke ..... Yes No
    c. Osteoporosis ..... Yes No
    d. Cancer requiring IV chemotherapy ..... Yes No
    e. Asthma or hay fever ..... Yes No
    f. Fainting spells or seizures ..... Yes No
    g. Diabetes ..... Yes No
    h. Hepatitis, jaundice, or liver disease ..... Yes No
    i. AIDS or HIV infection ..... Yes No
    j. Thyroid problems ..... Yes No
    k. Respiratory problems, bronchitis, etc. .... Yes No
    l. Sleep apnea or snoring during sleep ..... Yes No
    m. Stomach ulcer or hyperacidity ..... Yes No
    n. Kidney trouble ..... Yes No
    o. High or low blood pressure ..... Yes No
    p. Sexually transmitted disease ..... Yes No
    q. Epilepsy/other neurological disease? ..... Yes No
    r. Problems with the spleen ..... Yes No
12. Have you had abnormal bleeding? ..... Yes No
    Or required a blood transfusion? ..... Yes No
13. Do you have any blood disorder, such as anemia? ..... Yes No
14. Have you been treated for a tumor? ..... Yes No
15. Do you smoke or vape? ..... Yes No
16. Are you allergic or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or other antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates, sedatives, sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Other_____

Women

17. Are you pregnant? ..... Yes No
18. Do you have any menstrual problems? ..... Yes No
19. Are you nursing? ..... Yes No
20. Are you taking birth control pills? ..... Yes No

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. Forooghi

_____
Signature of Patient (or Patient's Guardian)