Annual Medical History Update

Patient Name: _____ **DOB:** _____ **SSN:** _____

Address: _____ **City, State, ZIP:** _____

Cell# : _____ **Home #:** _____ **Employer/ Work #:** _____

Emergency Contact: _____

Do you have any of the following diseases or medical problems?

- ☐ Active Tuberculosis
- ☐ Been exposed to anyone with tuberculosis
- ☐ Persistent cough greater than a 3-week duration
- ☐ Cough that produces blood

If you marked any of the above items, please stop and return this form to the receptionist.

Primary Care Dr: _____ **Date of last visit:** _____

Address & Phone #: _____

Have you had any serious illness, operation or been hospitalized in the last five years? ☐ No ☐ Yes
If yes, please explain: _____

Are you currently pregnant? ☐ No ☐ Yes **If yes, how many months?** _____
Are you taking any medications? ☐ No ☐ Yes

Please list below medications, vitamins and/or herbal supplements you currently take:

Name of Medication:	*Reason:*
_____	_____
_____	_____
_____	_____

Are you taking, or have you taken in the past, any drugs for bone density, osteoporosis or osteopenia? ☐ No ☐ Yes
If yes, list date you started/stopped : _____; **the name of the medication:** _____

Please check if you are allergic to any of the following:

- ☐ Local anesthetics
- ☐ Penicillin/other antibiotics
- ☐ Barbiturates, sedatives, sleeping pills
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Other
- ☐ Codeine/other narcotics
- ☐ Latex sensitivity

The following conditions may require a pre-medication with antibiotics. Please check if any of them apply to you:

- ☐ Heart murmur
- ☐ Prosthetic implant:
  Joint & date: _____
- ☐ Artificial (prosthetic) heart valve
- ☐ Congenital heart disease (CHD)
  - ☐ Unrepaired, cyanotic CHD
  - ☐ Repaired (completely) in last 6 months
  - ☐ Repaired CHD with residual defects
- ☐ Mitral valve prolapse
- ☐ Surgery with pins
  Area & date: _____
- ☐ Previous infective endocartitis
- ☐ Rheumatic fever
- ☐ You are undergoing treatment for cancer
- ☐ Transplant surgery
  Organ & date: _____
- ☐ Damaged valves in transplanted heart

You have taken the diet drug Fen Phen:
If yes, Date: _____

Please indicate if you have ever had or been treated for any of the following diseases or medical problems:

- ☐ Abnormal bleeding
- ☐ Abnormal blood pressure
- ☐ AIDS/ARC
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma / Hay Fever
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/Alcohol abuse
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting spells
- ☐ Heart attack/Stroke
- ☐ Heart attack/Stroke
- ☐ Heart Disease
- ☐ Hepatitis A / B / C
- ☐ HIV +
- ☐ Jaundice
- ☐ Kidney trouble
- ☐ Mental Health Disorder
  _____
- ☐ Pacemaker
- ☐ Radiation therapy
- ☐ Sexually Transmitted Infection
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Ulcers
- ☐ Bruises Easily

_____ I have been made aware of the privacy policies of Henniker Family Dentistry (please initial).

Patient's Signature _____ Date: _____