**Patient Medical History - Update**

Patient Name:                     Sex: M[ ]  F[ ]  Date of Birth:

 **PLEASE DESCRIBE ALL YES ANSWERS**

1. Have you been hospitalized in the last 5 years due to surgery or illness? [ ] yes [ ] no
2. Are you undergoing any medical treatment? [ ] yes [ ] no
3. Are you presently taking any medications or supplements? [ ] yes [ ] no
4. Are you currently undergoing, or have you ever had, Bisphosphonate therapy (Fosamax, Boniva, Reclast, Actonel, Aredia, Zometa)?

 [ ] yes [ ] no

1. Have you ever had a reaction to any medication? [ ] yes [ ] no
2. Do you have any allergies? [ ] yes [ ] no
3. Do you bleed abnormally after cuts or extractions? [ ] yes [ ] no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Have you ever had radiation therapy? [ ] yes [ ] no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Have you taken steroids (Cortisone) in the past 2 years? [ ] yes [ ] no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Do you smoke, use smokeless tobacco, or vape? How much/often? [ ] yes [ ] no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **(Women)** Are you Pregnant? [ ] yes [ ] no (Due Date:                                      )
8. Are there any other physical, mental, or emotional problems we should be aware of?

 [ ] yes [ ] no

1. Please check if you have ever had any of the following:

[ ]  AIDS/HIV

[ ]  Alcohol Addiction

[ ]  Anemia

[ ]  Arthritis

[ ]  Artificial Heart Valve

[ ]  Asthma

[ ]  Blood Disease

[ ]  Cancer

[ ]  Chemotherapy

[ ]  Cold Sores

[ ]  Congenital Heart Defect

[ ]  Diabetes

[ ]  Drug Addiction

[ ]  Epilepsy

[ ]  Fainting

[ ]  Glaucoma

[ ]  Hearing Problems

[ ]  Heart Disease

[ ]  Heart Surgery

[ ]  Hepatitis A / B / C

[ ]  High Blood Pressure

[ ]  High Cholesterol

[ ]  Joint Replacement

[ ]  Kidney Disease

[ ]  Learning Disabilities

[ ]  Liver Disease

[ ]  Mental Health Disorder

[ ]  Osteoporosis

[ ]  Pacemaker

[ ]  Respiratory Disorder

[ ]  Sleep Apnea/Disorder

[ ]  Stroke

[ ]  Thyroid Disease

[ ]  TMJ/Jaw Issues

[ ]  Tuberculosis

Please explain any checked responses

**I have been informed of Mequon Dental Group’s adherence to required Privacy and PHI Practices as dictated by the Health Insurance Portability & Accountability Act (HIPAA).**

**Signature:                                          Date:**