*Gerald M. Marlin, DMD, PC*

# Medical History UPDATE

**PATIENT INFORMATION - Update**

[ ]Mr. [ ]Mrs. [ ]Ms. [ ]Dr. FIRST NAME_____ M.I._____ LAST_____

STREET ADDRESS_____ _____ CITY_____STATE_____ZIP_____

HOME PHONE ( )_____ CELL PHONE ( )_____ BUS. PHONE ( )_____

EMAIL ADDRESS _____ MARITAL STATUS _____

PREFERRED CONTACT METHOD for CONFIRMATION OF APPOINTMENTS: [ ]Home [ ]Cell [ ]Business [ ]Email

EMPLOYER_____ BUSINESS ADDRESS_____

NAME OF SPOUSE_____SPOUSE'S EMPLOYER_____ SPOUSE'S BUS. PHONE ( )_____

NAME OF PHYSICIAN_____ PHYSICIAN'S PHONE ( )_____

PHYSICIAN'S ADDRESS _____ CITY_____STATE_____ZIP_____

IN CASE OF EMERGENCY: NAME OF CONTACT_____ RELATIONSHIP TO CONTACT _____

CELL PHONE ( ) _____ BUS.PHONE ( ) _____ HOME PHONE ( )_____

**Please answer the following questions by indicating YES OR NO. Medical conditions can impact dental treatment. Your answers are confidential.**

| **HEALTH HISTORY - Update** | **YES** | **NO** | **NOTES** |
|---|---|---|---|
| Date of Last **Physical** Examination: | | | |
| Are you being treated by a Physician Now? | | | |
| Have You Been Hospitalized Or Had A Serious Illness Within The Past Five Years? If Yes, Explain | | | |
| Do you PRE-MEDICATE for dental treatment? | | | |

| **ALLERGIES – Are you allergic to… or Had a reaction to…** | **YES** | **NO** | **NOTES** |
|---|---|---|---|
| [ ]Local Anesthetics (Novacaine / Xylocaine) | | | |
| [ ]Penicillin [ ]Amoxicillin [ ]Other Antibiotics | | | |
| [ ]Barbiturates [ ]Sedatives [ ]Valium [ ]Sleeping Pills | | | |
| [ ]Aspirin [ ] Ibuprofen (Advil, Motrin) | | | |
| [ ]Codeine [ ]Vicodin [ ]Narcotics [ ]Other Codeine Derivatives | | | |
| [ ]Latex products | | | |
| [ ]Sulfa/Sulfites | | | |
| [ ]Other – List allergies other than drug allergies | | | |

| **MEDICATIONS – Are you NOW taking the following medications….** | **YES** | **NO** | **NOTES** |
|---|---|---|---|
| [ ]Antibiotics<br>May alter effectiveness of oral contraceptives | | | |
| Anticoagulants:<br>[ ]**Aspirin** [ ]Blood Thinners<br>[ ]Coumadin [ ]Plavix<br>[ ]Ginko Biloba [ ]Vitamin E | | | |
| [ ]High Blood Pressure | | | |
| [ ]Cortisone (Steroids) | | | |
| [ ]Tranquilizers or MAO Antidepressant | | | |
| [ ]Antihistamines | | | |
| [ ]Insulin [ ]Orinase [ ]or Similar Drug | | | |
| [ ]Digitalis [ ]Nitroglycerin<br>[ ]Drugs for Heart Trouble | | | |
| Bisphosphonate drugs:<br>[ ]**Aredia** [ ]**Boniva** [ ]**Fosamax**<br>[ ]**Actonel** [ ]**Zometa** [ ] _____ | | | |
| Please list other medications you are currently taking: | | | |

| SINCE YOUR LAST UPDATE… HAVE YOU HAD ANY OF THE FOLLOWING… | YES | NO | NOTES |
|---|---|---|---|
| [ ]Rheumatic Fever | | | |
| [ ]Heart Murmur | | | |
| [ ]Mitral Valve Prolapse<br>[ ]Congenital Heart Lesions | | | |
| [ ]Heart Valve Replacement<br>[ ]Prosthetic Joint Replacement<br>[ ]Organ Replacement | | | |
| [ ]Bypass Surgery [ ]Heart Attack | | | |
| [ ]Chest pain (Angina) | | | |
| [ ] Irregular Heart Beat/Tachycardia | | | |
| [ ]Cardiac Pacemaker | | | |
| [ ]Stroke | | | |
| [ ]Convulsions [ ]Seizures [ ]Epilepsy | | | |
| [ ]Diabetes | | | |
| [ ]Glaucoma | | | |
| [ ]Anemia | | | |
| Abnormal Bleeding with<br>[ ]Extractions [ ] Surgery | | | |
| [ ]High Blood Pressure | | | |
| [ ]Low Blood Pressure | | | |
| [ ]Hepatitis [ ] Jaundice [ ]Liver Disease | | | |
| [ ]Kidney [ ]Bladder Disorder | | | |
| [ ]Respiratory Disorder [ ]Asthma<br>[ ]Emphysema [ ]Shortness of Breath | | | |

| SINCE YOUR LAST UPDATE… HAVE YOU HAD ANY OF THE FOLLOWING… | YES | NO | NOTES |
|---|---|---|---|
| [ ]Arthritis [ ]Joint Disease<br>[ ]Swollen Ankles | | | |
| [ ]Fainting Spells | | | |
| [ ]Mental Health Therapy | | | |
| [ ]Fever Blisters [ ]Cold Sores<br>[ ]Infections of the Mouth | | | |
| [ ]Thyroid trouble [ ]Goiter | | | |
| [ ]Stomach Ulcers [ ]GERD-Acid Reflux | | | |
| [ ]Alcoholism [ ]Drug dependency | | | |
| Do you smoke or use tobacco products? | | | |
| Surgery or Radiation Treatment for a Tumor, Growth, or Other Condition of Your Head or Neck? | | | |
| [ ]Chemotherapy [ ]Radiation [ ]Cancer | | | |
| Blood Transfusion(s) | | | |
| Sexually Transmitted Diseases (STD) | | | |
| Have You Been Tested for HIV Infection (AIDS)? Date _____<br>Result of Test: [ ] Positive [ ] Negative | | | |
| Do You Have Clicking, Popping, or Pain in the Jaw Joints? | | | |
| **Women:** Are You Pregnant? | | | |
| **Women**: Are You Taking Birth Control Pills?<br>(Warning: Antibiotics May Interfere with Effectiveness of Oral Contraceptives) | | | |
| **Women**: Are You on Hormonal Therapy? | | | |

Since the last medical form you completed, are there any other medical conditions that have occurred? If Yes, Explain

_____

_____

COMMENTS _____

**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 prosthodontist, associate dentist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I understand that I am responsible for notifying my prosthodontist of any medical changes upon each visit.

**Patient Signature** _____ Date _____
*(Parent or Guardian if minor)*