BEAR TOOTH
DENTAL

Patient Medical History-Update

NAME:___________________________________

Physician___________________________________ **Date of Last Exam**_______/________

1. Are you under medical treatment now? Yes_______ No_______
   If yes, please explain____
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 12 months? Yes_______ No_______
   If yes, please explain____
3. Are you currently taking any new medication (prescription/non-prescription/herbal supplements) Yes_______ No_______
   If yes, please explain____
   ____
4. Do you use any tobacco products? Yes_______ No_______
5. Have you had any of these symptoms in the last 3 days: shortness of breath, fever, cough, sore throat, chills, loss of smell/taste? Yes___ No___
6. Are you allergic to or have you had any reactions to the following?

Aspirin	Yes____	No____
Latex Rubber	Yes____	No____
Local Anesthetics (ex. Lidocaine)	Yes____	No____
Any Metals (ex. Nickel, mercury, etc.)	Yes____	No____
Penicillin or any other antibiotics	Yes____	No____
Sedatives	Yes____	No____
Sulfa Drugs	Yes____	No____

Other_______________________________________

7. Are you taking any blood thinners? Yes____ No___
8. Are you Oral bisphosphonates (medication for osteoporosis)?
   Yes____ No____

Women Only:

1. Are you pregnant or do you think you might be?
   Yes____ No____
2. Are you nursing? Yes____ No_____
3. Are you taking oral contraceptives? Yes____ No___

Please circle if any of the following applies to you within the last 12 months:

ANEMIA
ANGINA
ARTHRITIS
ASTHMA
AUTOIMMUNE DISEASE
BLOOD DISEASE
CANCER
CARDIAC PACEMAKER
CHEMOTHERAPY

DIABETES
DIZZINESS
EMPHYSEMA
EPILEPSY/CONVULSIONS
EXCESSIVE BLEEDING
FAINTING/SEIZURES
GLAUCOMA
HEAD INJURIES
HEART DISEASE/ATTACK
HEART MURMUR

HEPATITIS
HIGH/LOW BLOOD PRESSURE
HIV
JOINT REPLACEMENT
KIDNEY DISEASE
LEUKEMIA
LIVER DISEASE
MENTAL DISORDER
MITRAL VALVE PROLAPSE
NERVOUS DISORDER

RADIATION TREATMENT
RECENT WEIGHT LOSS
RESPIRATORY PROBLEMS
RHEUMATIC FEVER
SINUS PROBLEMS
STOMACH PROBLEMS/ULCER
STROKE
THYROID PROBLEMS
TUBERCULOSIS
OTHER________________________

Any Other Changes in your health (within the last 12 months):

Patient's Signature____ Date________/_______/_________