Boulos Dental Care - Medical History Update

First Name:_____ MI:_____ Last Name:_____

Address:_____ City:_____ Zipcode:_____

Home Phone Number:_____ Cell Phone Number:_____

Social Security: _____ Email:_____

Emergency Contact: Name:_____ Phone Number:_____

1. Are you taking any medications, including vitamins and supplements? Yes No

*If yes, please list:*_____

_____

2. Do you have any allergies? Yes No

*If yes, please list, including reaction:*_____

_____

3. Do you take a premedication for dental treatment? Yes No
4. Are you taking or have you taken bisphosphonates (ie: Fosamax, Boniva, Actonel, etc)? Yes No
5. Have you ever used or do you currently use tobacco products? Yes No - When did you quit? _____

__Cigarettes __ Pipe __Chew __Cigars __E-cigs; How much? _____ How often? _____

6. [Women] Are you pregnant? Yes No Are you breastfeeding? Yes No
7. Do you have or have you ever had any of the following (circle all that apply):

AIDS/HIV Positive	Heart Disease	Rheumatic Fever
Anemia	Heart Murmur	Stroke
Arthritis	Hepatitis (Type __)	Tuberculosis
Asthma/Hay Fever	High or Low Blood Pressure	Tumor/Cancer
Blood Transfusion	Jaundice	Ulcers
Chemical Dependency	Joint Implant	Thyroid Disease
Circulatory Problems	Kidney Problems	Dizziness/Vertigo
Congenital Heart Defect	Learning Disability	Sinus Trouble
Diabetes (Type I / Type II)	Mental Health Care	Sleep Apnea
Epilepsy/Seizures	Mitral Valve Prolapse	Other:_____
Fainting Spells	Osteoporosis	
Gastrointestinal Disease	Radiation/Chemotherapy	

8. Any other health updates, hospitalizations, or surgeries since your last visit? _____

All of the information is correct to the best of my knowledge.

Patient Signature:_____ Date: _____