THIELBAR FAMILY DENTAL
Medical History Update

Patient name:________________________ **Phone #:**______________ Cell #:________________
Address:__________________________________ **Dental Insurance:** ______________________
EMAIL: __________________________________ **(ONLY USED FOR APPOINTMENT REMINDERS)**

1. Have you been under the care of a medical doctor during the past two years (other than routine checkups and physicals)?........Yes No
   If yes, for what? ____
2. Primary Physician's name and phone number: ____________________________________
3. Have you been hospitalized in the last five years? ....Yes No
   If yes, for what? ____
4. Please list any medications, drugs, vitamins/supplements, or pills (including any over-the-counter medications) you are currently taking:____
   ____
5. Please list any medications, drugs, vitamins/supplements, or pills (including any over-the-counter medications) **<u>you have taken in the last two years</u> that are not listed above**____________________________________
6. **Are you aware of having an allergic or adverse reaction to any medication or substance?... Yes No**
   If yes, please list ____
7. Indicate which of the following you have had, or have at present. **<u>Circle 'Yes' or 'No' for each item.</u>**

a. Heart (Surgery, Disease, Attack)... Yes No
   If yes, indicate type(s) & date(s):__________
   ____
b. Artificial Heart Valve................Yes No
c. Heart Pacemaker.......................Yes No
d. Bacterial Endocarditis............... Yes No
e. Congenital Heart Disease........... Yes No
   If yes, indicate type:____________________
f. Stroke(s)...............................Yes No
   If yes, indicate date(s)___________________
g. Artificial Joints (hip, knees, etc.)... Yes No
   If yes, indicate type(s) & date(s)___________
   ____
   Previous Prosthetic infection?....... Yes No
h. History of bisphosphonates therapy or bone building medications such as Zometa or Aredia .... Yes No
i. Prednisone or Cortisol Medicine... Yes No
j. Diabetes................................Yes No
   Type I or Type II (please circle type)

k. Immuno Suppression.......Yes No
l. Rheumatism............... Yes No
m. Osteoporosis............... Yes No
n. High Blood Pressure...... Yes No
o. Chest Pain.................. Yes No
p. Swollen Ankles........... Yes No
q. Kidney Trouble........... Yes No
r. Ulcers...................... Yes No
s. Thyroid Problems........ Yes No
t. Glaucoma.................. Yes No
u. Emphysema................ Yes No
v. Chronic Cough............ Yes No
w. Tuberculosis............... Yes No
x. Diet (Special/Restricted).. Yes No
y. Asthma..................... Yes No
z. Hay Fever.................. Yes No
aa. Allergies or Hives......... Yes No
bb. Latex Sensitivity........... Yes No
cc. Tumors...................... Yes No
dd. Chemotherapy............. Yes No

ee. Radiation Therapy......... Yes No
   If yes, location(s) on body?
   ____
ff. Hepatitis..................... Yes No
   If yes, A, B, or C? ____________
gg. Headaches......................Yes No
hh. H.I.V./A.I.D.S............. Yes No
ii. Cold Sores/fever blisters...Yes No
jj. Blood transfusion......... Yes No
kk. Hemophilia................. Yes No
ll. Sickle Cell Disease.........Yes No
mm. Bruise Easily............ Yes No
nn Liver Disease............... Yes No
oo. Yellow Jaundice........... Yes No
pp. Neurological Disorders.... Yes No
qq. Epilepsy or Seizures....... Yes No
rr. Fainting or Dizzy Spells...Yes No
ss. Nervous or Anxious........ Yes No

8. Do you experience any popping or clicking in your jaw joint?.. Yes No
9. Have you had an unexplained significant weight gain or loss in the past year? .... Yes No
10. Do you have any disease, condition, or problem not listed? .... Yes No
   If yes, please list ____
11. **Women Only – Are you: Pregnant?** Yes No **Nursing?** Yes No **Take birth control medication or shots?** Yes No
   Name/Type: __________________________

Patient or Parent/Legal Guardian signature:____________________________________**Date:**________________

For Office Use Only

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