**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:**