LAKELANDSMILE
EXPERTS

Section V **Medical History Update**

Name: _____ Date:_____

Have you had any serious illnesses or operations since your last visit? If yes, please describe

_____

_____

Are you taking any blood thinners? (Aspirin, Plavix, Coumadin) _____

(Women) Are You Pregnant? ☐ Yes ☐ No How far long? _____Taking Birth Control? ☐ Yes ☐ No

Are you taking any bisphosphonates? (Actone, Fosamax) _____

Are you taking any new medications since your last visit? If yes please list medication and reason for use below

_____

_____

Check if you have any of the following: Check None, if you don't have any of the following or Fill out Other Section.

☐ AIDS	☐ Diabetes	☐ Hepatitis	☐ Pacemaker
☐ Artificial Heart Valve	☐ Epilepsy	☐ Herpes	☐ Rheumatic Fever
☐ Artificial Joints	☐ Fainting	☐ High Blood Pressure	☐ Scarlet Fever
☐ Asthma	☐ Heart Murmur	☐ HIV Positive	☐ Thyroid Problems
☐ Back Problems	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Stroke	☐ Excessive Bleeding	☐ **NONE**

☐ Heart Problems – Describe: _____

Is there anything you would like to discuss with the Doctor today during your visit?

_____

_____

_____

Do you have any new dental concerns since your last visit?

_____

_____

_____

Patient Signature: _____

Doctor Signature: _____