MEDICAL HISTORY UPDATE

Patient Name_____Birthdate_____Date_____

List allergies to drugs / materials / foods_____

List current medications_____

Pre-Med Required? YES NO If yes, reason_____type_____dosage_____

Tobacco user? YES NO If yes, type_____ amount_____ number of years_____

Female patients: Are you pregnant? YES NO If yes, due date_____

PAST AND CURRENT MEDICAL CONDITIONS (MARK ALL THAT APPLY):

CONDITION	YES	NO
Under physician's care? Details:		
Hospitalization in last 5 years? Details:		
Past use of Fen-Phen?		
Heart trouble / disease?		
Rheumatic fever?		
Heart murmur?		
Mitral valve prolapse?		
Heart Surgery?		
Artificial heart valves?		
Pacemaker and/or defibrillator?		
Artificial joints?		
History of organ transplant?		
High/Low blood pressure?		
Stroke?		
Bleeding problem?		
Hemophilia?		
Anemia?		
Leukemia?		
Lung disease?		
Emphysema?		
Shortness of breath?		
Asthma?		
Sleep apnea?		
Tuberculosis?		
Sinus trouble?		
Cancer?		
Radiation treatment to head/neck?		

CONDITION	YES	NO
Past use of Bisphosphonates (eg. Aredia / Fosomax)?		
History of infective endocarditis?		
Chemotherapy?		
Kidney disease?		
Dialysis?		
Eating disorder?		
G.I. problems : reflux? Ulcer?		
Immunological disease?		
Sjogrens disease?		
Fibromyalgia?		
Other autoimmune disease (eg. lupus, pemphilus)?		
Jaw pain?		
Arthritis or other joint disorders?		
Diabetes? Type: Controlled? Y N		
Hypoglycemia?		
Severe/frequent headaches?		
Diagnosed depression?		
Neurologic disorders?		
Convulsions?		
Epilepsy / seizures?		
Fainting/ dizziness?		
AIDS / HIV positive?		
Sexually transmitted disease?		
Hepatitis?		
Thyroid disease?		
Glaucoma?		
Alcohol or chemical dependency?		

AUTHORIZATION: ***I have reviewed the information and it is accurate to the best of my knowledge. I understand it is my responsibility to inform the office of Jeffrey J. Tibbs, DDS, PA of any changes to the information I have provided.***

Signature_____**Date**_____

_____adult patient _____parent or guardian