W E S T E R N R E S E R V E P E R I O D O N T I C S , I N C .

Charlene B. Krejci, D.D.S., M.S.D. **Sasha B. Ross**, D.M.D., M.S.

MEDICAL HISTORY UPDATE

(The following information is strictly confidential.)

Mr., Ms., Dr. _____ Birth Date _____ Age ____ Date _____

Address _____ City _____ ZIP _____

Phone (circle contact preference): (H) (___)_____ (W) (___)_____ Cell (___)_____

Emergency Contact _____ Phone (___) _____

E-mail _____ General Dentist _____ Phone (___) _____

Name of Physician _____ Date of last physical exam _____

Are you under active medical care? ❑No ❑Yes If yes, for what? _____

(1) Have there been any changes in your general health recently? ..... ❑No ❑Yes
(2) Have you lost or gained an excessive amount of weight recently? ..... ❑No ❑Yes
(3) Have you been seriously ill within the last year? ..... ❑No ❑Yes
(4) Have you had surgery (an operation) within the last year? ..... ❑No ❑Yes
(5) Have you been treated for a growth or tumor? ..... ❑No ❑Yes
(6) Have you ever had excessive bleeding requiring treatment? ..... ❑No ❑Yes
(7) Have you experienced chest pain or shortness of breath going up a flight of stairs? ..... ❑No ❑Yes
(8) Have you noticed an increase in frequency of urination? ..... ❑No ❑Yes
(9) Have you noticed an increase in thirstiness? ..... ❑No ❑Yes
(10) Have you been told to take an antibiotic before your dental treatment? ..... ❑No ❑Yes
(11) Please check any of the following which you have had: ❑ **NONE OF THE BELOW**

❑Anemia	❑Artificial Heart Valve	❑Steroid/Cortisone treatments	❑HIV/AIDS
❑Arthritis	❑Mitral Valve Prolapse	❑Epilepsy/Seizures	❑Skin Disease
❑Artificial Joint	❑Heart Murmur	❑Asthma/Emphysema	❑Thyroid Disorder
❑Cancer	❑High Blood Pressure	❑Rheumatic Fever	❑Fainting/Dizziness
❑Chest Pain	❑Low Blood Pressure	❑Tuberculosis	❑Hepatitis/Jaundice
❑Heart Attack	❑Stroke	❑Glaucoma	❑Liver Disease
❑Heart Disease	❑Diabetes	❑Ulcers	❑Venereal Disease
❑Heart Surgery	❑Family History of Diabetes	❑Kidney Disorder	(Herpes, Gonorrhea,
❑Heart Pacemaker	❑Osteoporosis		Syphilis)
❑Other_____			

(12) Are you presently undergoing psychiatric or psychological therapy? ..... ❑No ❑Yes
(13) Have you recently experienced an unusual reaction to local anesthetic? ..... ❑No ❑Yes
(14) Please check which of the following you are allergic to: ❑None ❑Penicillin ❑Aspirin ❑Codeine ❑Latex ❑Other _____

(15) Please list any prescription drugs or medications which you are currently taking or have taken within the past year and the reasons for their use: ❑N/A _____

(16) Are you presently taking any herbal or vitamin preparations? ❑No ❑Yes If yes, please list: _____

(17) Do you take aspirin on a daily basis? ❑No ❑Yes
(18) Do you take nonsteroidal anti-inflammatories (like Advil) on a daily basis? ❑No ❑Yes
(19) Do you smoke or chew tobacco? ❑No ❑Yes If yes, how much? _____
(20) WOMEN are you pregnant at this time? ❑No ❑Yes Do you take birth control pills or have you? ❑No ❑Yes
(21) WOMEN are you in or have you had menopause? ❑No ❑Yes A hysterectomy or ovariectomy? ❑No ❑Yes
(22) Is there any additional information which will help us to help you? ..... ❑No ❑Yes

This medical/dental history is accurate to the best of my knowledge. _____
Signature

For office use only: _____