

GARY L. HARRIS, D.D.S., P.C.

Medical History Update

Date: _____
Patient Name: _____
Address: _____
Phone: _____

Employer: _____
Employer Address: _____
Business Phone: _____

1. Physician's Name: _____
Date of last physical: _____
Are you seeing any specialists?.....Yes or No
If yes, specialist's name and reason: _____

2. Have you been a patient in the hospital during the past five years?.....Yes or No
If yes, for what? _____

3. Are you taking any medications, drugs, or pills now?.....Yes or No
If yes, please list medication and why _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance?.....Yes or No
If yes please list: _____

5. Indicate which of the following you have had, or have at present.

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart -Surgery/Disease/Attack | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hepatitis A/ infectious B/ Serum |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> A.I.D.S. |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> H.I.V. Positive |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Diet (Special/Restricted) | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Nervous/Anxious |
| <input type="checkbox"/> Artificial Joints (Hip/Knee/Etc.) | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Tumors | <input type="checkbox"/> Psychiatric/Psychological |

6. Do you have or have you had any disease, condition, or problem not listed:..... Yes or No
If yes please list: _____

7. Do you use more than two pillows to sleep?.....Yes or No

8. Have you lost/gained more than 10 pounds in the past year?.....Yes or No

9. Women: Are you Pregnant? Yes No If yes, ___months Nursing? Yes No Taking Birth Control Pills? Yes No

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: _____ Date: _____