NORTH APPLETON
DENTISTRY LLC
3521 COMMERCE CT – APPLETON, WI 54911 – (920)-734-7730

Medical History Update

Patient Name_____ **Date of Birth**___/_____/_____

Cell phone _____ **Do you want to receive text messages? YES NO**

Do you want to receive email confirmations? YES NO If Yes, Email address _____

Are you currently being treated by a doctor for something other than routine care O Yes O No *(reason?)*_____

If yes, Physician's Name: _____ Phone Number: _____

Please circle the correct response:

Yes No Do you have to take a Pre-medication prior to dental work? If Yes, did you take it today? **YES NO**
Yes No Are you allergic to any medications? List:_____
Yes No Are you sensitive to latex, metals, or other substances? List: _____
Yes No Women - Are you pregnant or trying to become pregnant? Women – Are you nursing? Yes No
Yes No Have you been told that you have or have you been treated for heart disease?
Yes No Do you have a pacemaker, cardiac stents or artificial heart valves? If yes, date of placement: _____
Yes No Do you have high or low blood pressure? HIGH LOW (If yes, please circle)
Yes No Have you had major illness or any surgery? What _____
Yes No Have you had radiation or chemotherapy? For what _____ _____
Yes No Have you taken any bisphosphonates? (Fosamax, Boniva, Zometa, Aredia) For how long? _____
Yes No Do you have artificial joints? If yes, date of placement: _____
Yes No Are you on any blood thinners (including daily aspirin)? List: _____
Yes No Have you had problems with excessive bleeding after a cut?
Yes No Do you have acid reflux or GERD?
Yes No Are you diabetic? Type I or II (circle) Medication _____
Yes No Do you have asthma or other respiratory problems? List: _____
Yes No Have you tested HIV positive or do you have ARC or AIDS?
Yes No Do you test positive for hepatitis? Circle which: A B C D
Yes No Do you use tobacco products? List which: _____ How much/day _____

Yes No Do you have any discomfort from your teeth or gums? Where: _____
Yes No Do your gums bleed or hurt when you brush or floss them? Where: _____
Yes No Does food catch between your teeth? Where: _____
Yes No Do you experience pain from heat, cold, or sweets? (Circle which one) Where: _____

Is there anything else we should know about your health, to safely treat you, not covered in the questions on this form?

_____

Please list all prescription medications, supplements, or herbals you regularly take below:
(There is a medication list on the clipboard of common medications, if needed)

…… …… ……
…… …… ……
…… …… ……

_____
Patient Signature & Date

_____
Updated Patient Signature & Date