NuLife Dental & Med Center
106 N Dean Rd Orlando, FL 32825
(407) 614-6161 info@mynulifedental.com

# MEDICAL HISTORY UPDATE FORM

| | | |
|---|---|---|
| Patient Name: | Date of Birth: / / | |
| Name of Physician: | Physician Phone Number: | |
| Phone Number: | Emergency Contact Name: | Emergency Contact Phone: |
| Mailing Address: | City: | State: Zip: |
| Email Address: | Preferred Pharmacy: | Pharmacy Phone: |

| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| 1. Hospitalization for illness or injury | □ | □ |
| 2. An allergic or bad reaction to any of the following: □ Aspirin, Ibuprofen, Acetaminophen, Codeine □ Penicillin □ Erythromycin □ Tetracycline □ Sulfa □ Local Anesthetic □ Fluoride □ Chlorhexidine (CHX) □ Iodine □ Metals (nickel, gold, silver) □ Latex □ Nuts □ Fruit □ Milk □ Red dye □ Other: ___________________________________ | □ | □ |
| 3. Heart problems, or cardiac stent within the last 6 months | □ | □ |
| 4. History of infective endocarditis | □ | □ |
| 5. Artificial heart valve, repaired heart defect (PFO) | □ | □ |
| 6. Congestive heart failure / Congenital heart disease | □ | □ |
| 7. Coronary artery disease | □ | □ |
| 8. Pacemaker or implanted defibrillator | □ | □ |
| 9. Artificial joints | □ | □ |
| 10. Heart murmur | □ | □ |
| 11. Rheumatic fever or scarlet fever | □ | □ |
| 12. □ High or □ Low blood pressure | □ | □ |
| 13. Heart attack or stroke | □ | □ |
| 14. Anemia or another blood disorder | □ | □ |
| 15. Prolonged bleeding due to a slight cut (or INR>3.5) | □ | □ |
| 16. Pneumonia, emphysema, shortness of breath, sarcoidosis | □ | □ |
| 17. Chronic ear infections, tuberculosis, measles, chicken pox | □ | □ |
| 18. Breathing problems (e.g. asthma/COPD, bronchitis, sinus congestion) | □ | □ |
| 19. Sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) | □ | □ |
| 20. Kidney disease | □ | □ |
| 21. Hepatitis, liver disease or jaundice | □ | □ |
| 22. Vertigo, fainting, dizziness | □ | □ |
| 23. Thyroid, parathyroid or calcium deficiency | □ | □ |
| 24. Hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) | □ | □ |
| 25. High cholesterol or taking statin drugs | □ | □ |
| 26. Diabetes. □ Type 1 or □ Type 2. HbA1C = ________________ | □ | □ |
| 27. Stomach or duodenal ulcer | □ | □ |
| 28. Digestive or eating disorders (e.g. acid reflux, bulimia, anorexia) | □ | □ |
| 29. Gastrointestinal disease (GERD, IBS/IBD, Celiac Disease, Crohns) | □ | □ |
| 30. Cortisone treatments | □ | □ |
| 31. Tuberculosis | □ | □ |
| 32. Tonsillitis | □ | □ |
| 33. Post-traumatic stress disorder (PTSD) | □ | □ |
| 34. Osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) | □ | □ |
| 35. Arthritis or gout | □ | □ |
| 36. Autoimmune diease (e.g. rheumatoid arthritis, lupus, scleroderma) | □ | □ |
| 37. Glaucoma | □ | □ |
| 38. Atrial Fibrillation (A-Fib) | □ | □ |
| 39. Head or neck injuries | □ | □ |
| 40. Epilepsy, convulsions (seizures) | □ | □ |
| 41. Neurologic disorders (e.g. Alzheimers, dementia, prion disease) | □ | □ |
| 42. Viral infections (cold sores) or bacterial infections (lyme disease) | □ | □ |
| 43. Any lumps or swelling in the mouth | □ | □ |
| 44. Hives, skin rash, hay fever | □ | □ |
| 45. STDs / HPV / STI | □ | □ |
| 46. Hepatitis (Type ______ ) | □ | □ |
| 47. HIV/AIDS | □ | □ |
| 48. Cancers, tumors or abnormal growths | □ | □ |
| 49. Radiation Therapy | □ | □ |
| 50. Chemotherapy, immunosuppresive medications | □ | □ |
| 51. Difficulties with stress management | □ | □ |
| 52. Psychiatric treatment, antidepressants, mood stabilizing meds | □ | □ |
| 53. Concentration problems or ADD/ADHD | □ | □ |
| 54. History of alcoholism | □ | □ |
| 55. Recreational drug use/chemical dependency | □ | □ |
| 56. Back problems | □ | □ |
| 57. Hypoglycemia | □ | □ |
| 58. Traumatic brain injury or concussion | □ | □ |
| **ARE YOU:** | | |
| 59. Presently being treated for any other illnesses | □ | □ |
| 60. Aware of a change in your health in the last 24 hours | □ | □ |
| 61. Often exhausted or fatigued | □ | □ |
| 62. Suffering from chronic pain or frequent headaches | □ | □ |
| 63. A smoker, have previoulsy smoked, or use chewing toboacco | □ | □ |
| 64. Suffering from anxiety | □ | □ |
| 65. Often unhappy or depressed | □ | □ |
| 66. Taking birth control pills | □ | □ |
| 67. Currently pregnant or nursing? If so, how many weeks? ______ | □ | □ |
| 68. Diagnosed with a prostate disorder | □ | □ |

## MEDICAL HISTORY UDPATE FORM (continued)

**Please list ALL medications, supplements, vitamins, antibiotics, and/or probiotics taken in the last 2 years**

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |

**Are there any other medical conditions you are currently diagnosed with, being treated for or were not mentioned above?** ☐ Yes ☐ No

If Yes, please describe below:

**Have you ever taken any of the following blood thinners? (Check all that apply)**

☐ Warfarin (Coumadin) ☐ Apixaban (Eliquis) ☐ Innohep (Heparin)

☐ Clopidogrel (Plavix) ☐ Rivarixaban (Xarelto) ☐ Dabigatran (Pradaxa)

☐ Aspirin ☐ Effient ☐ Ticlid

**Have you ever taken any of the following bisphosphonates? (Check all that apply)**

☐ Risendronate (Actonel/Atelvia) ☐ Alendronate (Fosamax) ☐ Ibandronate (Boniva)

☐ Zolendronate (Reclast/Zometa) ☐ Pamidronate (Aredia) ☐ Etidronate (Didronel)

☐ Denosumab (Prolia/Xgeva) ☐ Methotrexate

## INSURANCE INFORMATION

| | |
|---|---|
| Policy Holder: | Policy Holder Date of Birth: / / |
| Social Security # | Relationship to Patient: |
| Employer: | Insurance Company: |
| Subscriber I.D. # | Group # |

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR MEDICATIONS**

**Note: It is important for both the doctor and the patient to talk honestly about the patient's health before dental treatment starts. I have answered the above questions completely, accurately and to the best of my ability.**

Patient Signature: ______________________________ Date: ______________

Doctor Signature: ______________________________ Date: ______________