WESTERN RESERVE PERIODONTICS
Sayuri Smith, D.M.D., Ph.D.

**MEDICAL HISTORY UPDATE**

(The following information is strictly confidential.)

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

Address _____ City _____ ZIP_____

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

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

Name of Physician _____ Date of last physical exam _____

Emergency Contact _____ Phone (___)_____

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) Do you use marijuana? ❑No ❑Yes If yes, (medical ❑ or recreational ❑) how much? _____
(21) **WOMEN** are you pregnant at this time? ❑No ❑Yes Do you take birth control pills or have you? ❑No ❑Yes
(22) **WOMEN** are you in or have you had menopause? ❑No ❑Yes A hysterectomy or ovariectomy? ❑No ❑Yes
(23) 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: _____

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