JODY S. HARRISON, D.D.S.

MEDICAL HISTORY UPDATE

NAME:_____**DATE:**_____

ADDRESS:_____**CITY**_____**STATE**_____**ZIP**_____

PHONE:(H)_____**(WK)**_____**(CELL)**_____

E-Mail Address:_____

GENERAL DENTIST:_____**FAMILY PHYSICIAN:**_____

MEDICAL SPECIALIST(s):_____**Pharmacy/Address:**_____

EMERGENCY CONTACT:_____**PHONE:H)**_____**(CELL)**_____

MEDICAL HISTORY:

Height:_____ **Weight:** _____**WOMEN:Are you pregnant? Y/N**

List Medications or pills you currently take: _____

_____

_____

_____

Recent hospitalization?_____**For what?**_____

Are you experiencing any of the following symptoms: fever, cough, muscle aches, sore throat, loss of taste, change in smell? _____

Have you tested positive for COVID-19?_____ **HIV/Other:**_____

Smoke/vape/smokeless tobacco (circle one if yes) How many packs per day?_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: Please Mark Yes or No

Heart attack/MI_____**date**_____	**Angina/chest pain**_____
Heart valve replacement_____	**A Fib**_____**(anticoagulants?)**_____
Heart stent(s)_____	**Coronary artery bypass graft**_____
Bacterial endocarditis_____	**Rheumatic fever**_____
Pacemaker_____	**High/low blood pressure (circle)**_____
Congenital heart defect_____	**Stroke**_____**date**_____
Other heart problem(list)_____	**Bleeding problems/disorder**_____
Leukemia_____	**Anemia**_____**Blood transfusion**_____
Emphysema_____**COPD**_____	**Asthma**_____**date of last attack**_____
Tuberculosis_____**Chronic cough**_____	**Sinusitis**_____**Seasonal allergies**_____
Stomach ulcers_____	**Gastritis/colitis**_____
Hepatitis_____ **A/B/C/D (circle)**	**Liver disease**_____**Cirrhosis**_____
Jaundice_____	**Persistent diarrhea**_____
Artificial joint_____**date**_____	**Arthritis**_____**(Rheumatoid/Osteoarthritis)**
Osteoporosis_____**current medications**	**(Fosamax,etc?)**_____**How long?**_____
Thyroid trouble_____	**Diabetes**_____**Last HbA1c**_____
Skin rash_____	**Venereal disease**_____
Kidney trouble_____	**Bladder trouble**_____
Epilepsy/seizures____**last attack**____	**Fainting/syncope/dizzy spells** ____**(circle)**
History of cancer_____	**Chemotherapy**_____
Family history of cancer_____	**Drug/alcohol addiction**_____
Psychiatric treatment_____	**Organ transplant**_____
Sleep Apnea_____ **Do you use a CPAP**_____	**Do you use an Oral Appliance**_____

MEDICATION ALLERGIES Yes / No

Please list:_____

_____

SIGNATURE:_____

Revised 5/1/20