MALLOY & DEVINE
SIGNATURE DENTAL

MEDICAL HISTORY UPDATE

Patient Name: _____ **Date:** _____

Cardiac (Heart) Health

_____ Pacemaker
_____ Implanted Defibrillator
_____ Artificial Heart Valve
_____ Previous Infective Endocarditis
_____ Congenital Heart Disease
☐ Unrepaired cyanotic CHD
☐ Repaired completely
☐ Repaired with residual defects
_____ Arteriosclerosis
_____ Coronary Artery Disease
_____ Congestive Heart Failure
_____ Damaged Heart Valve
_____ Heart Attack
_____ Heart Murmur/Rhythm Disorder
_____ Rheumatic Heart Disease
_____ High Cholesterol

Respiratory (Breathing) Health

_____ Asthma (COPD)
_____ Bronchitis
_____ Emphysema
_____ Tuberculosis

Circulatory (Blood) Health

_____ Anemia
_____ Blood Transfusion
If yes, date _____
_____ Hemophilia
_____ High Blood Pressure
_____ Low Blood Pressure

Eye

_____ Glaucoma

Brain/Mental Health

_____ Dementia
_____ Anxiety and/or Depression
_____ Stroke
_____ Mental Health Disorders
_____ Neurological Disorders
_____ Post-traumatic Stress Disorder
_____ Traumatic Brain Injury
_____ Concussion
_____ Epilepsy

Autoimmune Diseases

_____ AIDS or HIV infection
_____ Lupus

Digestive Health

_____ Gastrointestinal Disease
_____ GE Reflux/GERD
_____ Stomach Ulcers

Cancer

Type _____
Date of Diagnosis _____
Chemotherapy _____
Radiation Treatment _____

Other

_____ Arthritis
_____ Diabetes (type I or II)
_____ Eating Disorder
_____ Hepatitis, jaundice, liver disease
_____ Immune Deficiency
_____ Kidney Problems
_____ Osteoporosis
☐ Injections ☐ IV ☐ Pill
_____ Rheumatoid Arthritis
_____ Sexually Transmitted Infection
_____ Thyroid Problems

ALLERGIES

_____ Aspirin
_____ Barbiturates, sedatives or sleeping pills
_____ Codeine or other narcotics
_____ Hay fever/seasonal allergies
_____ Iodine
_____ Latex (rubber)
_____ Local Anesthetics
_____ Metals
_____ Penicillin or Amoxicillin
_____ Other antibiotics
_____ Sulfa drugs
_____ Other _____

Current Medications

Medical and Surgical History

Please use an "x" to mark your answers to the following questions

Current physician's name and phone number _____

Has a physician or previous dentist recommend you take antibiotics before having dental work done? ☐ **Y** ☐ **N**

Have you had a serious illness, operation or been hospitalized within the last **2 years**? ☐ **Y** ☐ **N**

Have you had any type of joint replacement surgery within the last **2 years?** ☐ **Y** ☐ **N**

If yes, date _____

Have you had a heart valve replacement or heart surgery in the last **2 years?** ☐ **Y** ☐ **N**

Have you had a stroke or heart attack within the last **6 months?** ☐ **Y** ☐ **N**

If yes, date _____

Have you had an organ or bone marrow/stem cell transplant within the last **6 months?** ☐ **Y** ☐ **N**

Patient Name (PRINT) _____ **Date** _____

Patient Name (SIGN) _____ **Date** _____