Time 11:33 AM | David R. Mosser, DDS, LLC | Date 12/30/2019

2020 Updated Medical History Report

Patient Name: | Birth Date: | Date Created:

Please answer all questions by filling in Yes or No, and provide details where requested. Dr. Mosser will be pleased to discuss any questions you find to be unclear.

Are there any diseases that tend to occur in more than one member of your family?	◯ Yes ◯ No	If yes
NAME of your physician	◯ Yes ◯ No	If yes
Have you ever had a prolonged illness or hospitalization?	◯ Yes ◯ No	If yes
Have you ever had radiation therapy?	◯ Yes ◯ No	If yes
Are you currently taking drugs, medication, pills, liquids, or injections? (Please provide list)	◯ Yes ◯ No	If yes
Do you take Fosamax, Actonel, or other bisphosphonate (oral or intravenous)?	◯ Yes ◯ No	
Have you ever had prolonged bleeding from injury, tooth extraction or other surgery?	◯ Yes ◯ No	
Are you presently taking a blood thinner such as Coumadin, Plavix or asprin on a daily basis?	◯ Yes ◯ No	
Do you have a cardiac pacemaker?	◯ Yes ◯ No	

Are you now or have you ever taken

☐ Cortisone ☐ Steroids

Prophylactic antibiotics may be indicated prior to dental treatment in some cases. Have you ever had:

☐ Prosthetic joint or heart valve placed ☐ Previous infective endocarditis? ☐ Heart transplant, or any other heart sur

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Novocaine

Other: ☐ If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Hepatitis A, B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Hay Fever	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No	COPD	◯ Yes ◯ No

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____