Michael McNeill, DMD
GENERAL & COSMETIC DENTISTRY

Annual Update Form for Current Patients

Email:	Cell#:	Date:

Name: _____ Home phone: _____ Work Phone: _____

Address (if changed): _____

Did your dental insurance change?_____

MEDICAL INFORMATION

ALLERGIES: Please check yes or no to any allergies you have. To all **yes** responses please specify what you are allergic to type and severity of reaction.

Yes	No		Yes	No		Yes	No	
___	___	**Local anesthetics**	___	___	**Sulfa drugs**	___	___	**Aspirin**
___	___	**Antibiotics**	___	___	**Metal**	___	___	**Iodine**
___	___	**Hay fever / seasonal**	___	___	**Animals**	___	___	**Food**
___	___	**Latex (rubber)**	___	___	**Other**	___	___	**Codeine**
___	___	**Codeine**	___	___	**Barbiturates**	___	___	**Sedatives / sleeping pills**

_____

Do you or have you had Multiple myeloma or metastatic cancer? Date began? _____

Joint replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Bonivia, Reclast, Prolia) for osteoporosis or Paget's disease? _____

Since 2001, were you treated or are you presently scheduled to begin taking an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease?_____

Has a physician or previous dentists recommended that you take antibiotics prior to your dental treatment?_____

Name of physician or dentist making recommendation and phone number: _____

Women only: Are you pregnant? _____ Are you nursing? _____ Are you using birth control pills or hormone replacement therapy? _____

Please write yes or no:

Do you wear contact lenses? _____ Do you use controlled substances (drugs)? _____

Do use tobacco (smoking, dip)? _____If so how interested are you in stopping? Very / Somewhat / Not interested

Do you drink alcoholic beverages?_____ If yes, how much do you typically drink in a week? _____

Are you under the care of a physician? If yes then Name: _____

Has there been any change in your health within the past year? If yes then explain:_____
_____

Have you had a serious illness, operation or been hospitalized in the past 2 years? If yes then explain:_____
_____

Are you taking or have you recently taken any prescription or over the counter medicine? If yes, please list all, including vitamins, natural or herbal preparation on/or dietary supplements:

_____
_____

Please circle yes or no to indicate whether you have had or have any of the following conditions of diseases. If necessary explain yes answers below.

Artificial heart valve	yes / no	**Angina**	yes / no	**Arteriosclerosis**	yes / no	**Recurrent infections**	yes / no
Congenital heart defect	yes/ no	**Damaged heart valve**	yes / no	**Heart attack**	yes / no	**Heart disease**	yes / no
Heart Murmur/MPV	yes/no	**Heart surgery**	yes / no	**Low blood pressure**	yes / no	**High blood pressure**	yes / no
High cholesterol	yes / no	**Pacemaker**	yes / no	**Endocarditis**	yes / no	**Rheumatic fever**	yes / no
Abnormal bleeding	yes / no	**Anemia/Hemophilia**	yes / no	**AIDS / HIV**	yes / no	**Stroke**	yes / no
Autoimmune disease	yes / no	**Lupus/Erythematosus**	yes / no	**Asthma/Bronchitis**	yes/ no	**Emphysema**	yes / no
Tuberculosis	yes / no	**Cancer/chemotherapy**	yes / no	**Radiation**	yes/ no	**Excessive urination**	yes / no
Glaucoma	yes / no	**Eating disorder**	yes / no	**Ulcer**	yes / no	**Gastrointestinal issues**	yes / no
Stomach Problems	yes / no	**Hepatitis/Liver disease**	yes / no	**Kidney problems**	yes / no	**Thyroid problem**	yes / no
Arthritis/Rheumatoid	yes / no	**Seizure**	yes / no	**Epilepsy**	yes / no	**Osteoporosis**	yes / no
Sleep disorder	yes / no	**Snoring/sleep apnea**	yes / no	**Night Sweats**	yes / no		
Headaches/migraines	yes / no	**Mental disorder**	yes/ no				
Neurological disorder	yes / no	**Swollen neck glands**	yes / no	**Congestive Heart Failure**	yes / no		

Do you have any disease, condition, or problem not listed above that you think your dentist should know about? Please explain:

_____
_____
_____

Note: Both doctor and patient (s) are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understood the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth

above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature or Patient / Legal Guardian **Print Name** **Date**