Gibson Dental
GATEWAY TO TOTAL HEALTH & WELLNESS

# Patient Update

Patient Name:_____Date:_____

□ Married □ Single □ Partnered Social Security #_____ Birth date_____

Home Phone: _____ Cell: _____ **Best Contact □Home □Cell**

Email Address: _____

Home Address: _____City:_____Zip:_____

## MEDICAL HISTORY

Have you ever had any of the following diseases or medical problems? Please check Yes or No

### Cardiovascular

Congenital Heart Defect/MVP □ Yes□ No
Heart Disease □Yes □No
Blood Pressure Yes: □High □ Low □No
Heart Attack □ Yes □No
Date_____
Stroke □Yes □No
Date_____
Pace Maker □Yes □No
Date_____
Artificial Heart Valve □Yes □No Date

### Respiratory

Asthma □Yes □No
COPD □Yes □No
Emphysema □Yes □No
Shortness of Breath □Yes □No
Tobacco Habit □Yes □No
Seasonal Allergies □Yes □No

### Communicable Disease

HIV / AIDS □Yes □No
Hepatitis □A □B □C □Yes □No
Tuberculosis □Yes □No
STD (HPV, Syphilis) □Yes □No

### Cancer

Type & Year Diagnosed □Yes □No

_____

Chemotherapy □Yes □No
Radiation Treatment □Yes □No
Remission □Yes □No

### Endocrinology

Diabetes □Yes □No
□Insulin Dependent
□Non-Insulin Dependent
Thyroid □Yes □No □High □Low

### Blood Disorders

Sickle Cell Anemia □Yes □ No
Abnormal Bleeding □Yes □No
Anemia □Yes □No

### Miscellaneous

Arthritis □Yes □No
Artificial Joint(s) □Yes □No
Specify & Date _____
Joint Replacement □Yes □No
Specify &
Date_____
Osteoporosis □Yes □No
Frequent Headaches □Yes □No
Epilepsy □Yes □No
Frequent Sinus Infections □Yes □No
Glaucoma □Yes □No
Liver Disease □Yes □No
Kidney Disease □Yes □No
Dialysis □ Yes □ No

### WOMEN: if you are pregnant, we need a consent to treat from your OBGYN.

Use of birth control □Yes □No
Are you pregnant □Yes □No Week#_____
Are you nursing? □ Yes □ No
Do you have any health problems that need further clarification? □Yes □No
If yes, explain

_____
_____
_____

Please list current medication (if you have a list, we a happy to make a copy for you):

_____
_____

Signature _____ Date_____