Your Smile Solution

Updated Medical History -2020

Patient Name: _____ DOB: _____

Are there any changes to your medical History? Yes_____ No_____

If it is yes, please write down new **medical conditions or surgeries :** _____

_____

Medical conditions: existing / new condition: **Please circle YES or NO**

- High blood pressure: YES / NO - Diabetes I or II: YES / NO - Heart condition: YES / NO
- Cancer: YES / NO - Radiation: YES / NO - Chemotherapy: YES / NO
- Imnuno diseases YES / NO
- Joint replacement: YES / NO If yes, when: _____
- Stroke: YES / NO If yes, when: _____
- Allergies: YES / NO If yes: which:_____

Are there any changes to the medications that are you taking? Yes _____ No _____

If yes, please specify (dosage change / medication change):_____

_____

- Blood thinner : YES / NO -Aspirin: YES / NO - Fosamax: YES / NO

If it is yes, please **list new medications and vitamins:**_____

_____

Has your Dental insurance information changed? Yes _____ No _____

If it has, please call the office to provide the new dental Information.

Has your home address or cell phone number changed? Yes _____ No_____

New Address _____

New Cell phone number_____

SCREENING FOR COVID-19

Please circle YES or NO

Have you traveled internationally or domestically in the last month? YES _____ NO_____

Have you been in closed contact with another person who has been diagnosed with or under investigation for COVID-19? Yes _____ NO _____

Do you have or have you had fever in the last 4 weeks? YES_____ NO _____

Do you have or have you had a cough in the last 4 weeks? YES _____ NO _____

Do you have or have you had shortness of breath in the last 4 weeks? YES _____NO _____

If you answer yes to any of those questions, please contact your primary physician or public health department as soon as possible to determinate if you should be seen or tested.