Mosaic Dental
KELLY M. GIERA, DDS, PC

Name:________________________ **Date**:________________________

NEW Address/Phone:____

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Medical History Update Questions:

Are you in good health?.. YES NO

Has there been any change in your health in the past year?.. YES NO

Date of last physical exam:____

Are you currently under the care of a physician?.. YES NO

If YES, please explain:____

Name and Phone number for Physician____

Have you had any serious illness, operation or been hospitalized in the past 5 years?........................ YES NO

If YES, please explain:____

Please **LIST ANY** Medication you are taking, including over the counter/vitamins/supplements/etc____

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

Damaged heart valves or artificial valves, including heart murmur or rheumatic deart disease? YES NO

Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)?.. YES NO

Chest Pain?.. YES NO

Short of breath?.. YES NO

Swollen ankles?.. YES NO

Pacemaker?.. YES NO

Allergy to any medication/latex/other?.. YES NO

If YES, please explain:____________________

Sinus trouble?........ YES NO
Asthma/Hay Fever?........ YES NO
Fainting spells/Seizures?........ YES NO
Recent weight loss/gain?........ YES NO
Diabetes?........ YES NO
Hepatitis/Jaundice/Liver Disease?........ YES NO
AIDS/HIV Infection?........ YES NO
Thyroid problems?........ YES NO
Respiratory problems/Emphysema/Bronchitis/Other?........ YES NO
Arthritis?........ YES NO
Ulcers?........ YES NO
Kidney trouble?........ YES NO
Tuberculosis?........ YES NO
Persistent cough?........ YES NO
Swollen glands?........ YES NO
Low blood pressure?........ YES NO
STD?........ YES NO
Mental health problems?........ YES NO
Cancer?........ YES NO
Immune system problems?........ YES NO
Abnormal bleeding/Anemia?........ YES NO
Blood transfusion?........ YES NO
Adverse reaction to dental anesthesia/treatment?........ YES NO

Any condition not listed above or any other information the doctor should know?........ YES NO

If YES, please explain:____________________

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I certify that the above information is true and correct to the best of my knowledge. I will not hold my dentist, or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:____________________