Nu Smile Medical History Update Name: ____________________ Date: _______________

Address ____ E-Mail _____________________________

City ____________________________________ State ______________ Zip ___________

Date of last Physical Exam _____ / _____ / _____ Date of last Blood Panel / Test: _____ / _____ / _____

Date of last Echocardiogram _____ / _____ / _____ Diagnosis of that Echocardiogram: __________________________

TODAY'S BP: _______ / _______ Pulse: _______ Recorded by: _______ Date: ____ / ____ / ____

Heart, Cardiac, or Hypertension Medications you are currently on (Name / Strength / Frequency):

______________________/________/_____ X (s) per day Every_____ Hrs ______________________/________/_____ X (s) per day Every_____ Hrs

______________________/________/_____ X (s) per day Every_____ Hrs ______________________/________/_____ X (s) per day Every_____ Hrs

Have you recently experienced chest pain (Angina)? ☐ Yes ☐ No
Have you had chest pain (Angina) at rest? ☐ Yes ☐ No
Have you had recent changes in your medications for chest pain (Angina)? ☐ Yes ☐ No

What medications for chest pain (Angina) are you currently taking (Name / Strength / Frequency)?

______________________/________/_____ X (s) per day Every_____ Hrs ______________________/________/_____ X (s) per day Every_____ Hrs

If you have experienced a heart attack in the past, when were they? _____ / _____ / _____ _____ / _____ / _____

Have you had a coronary stent or a heart bypass in the last (CIRCLE) 6 months? 9 months? 12 months?

Are you currently on Plavix or any other anti-platelet protective medication? ☐ Yes ☐ No

Do you take a daily aspirin? ☐ Yes ☐ No If so, Strength / Frequency? _______/_____ X (s) per day Every_____ Hrs

Cholesterol Control Medications you are currently on (Name / Strength / Frequency):

______________________/________/_____ X (s) per day Every_____ Hrs ______________________/________/_____ X (s) per day Every_____ Hrs

Were you recently diagnosed with Diabetes? ☐ Yes ☐ No If so, when? ____ / _____ / _____ Type? I II

Are you currently taking insulin? ☐ Yes ☐ No If so, Strength / Frequency? _______/_____ X (s) per day Every_____ Hrs

Have you had a blood test screening for HbA1C hemoglobin level in the last 3 months? ☐ Yes ☐ No

Do you own a diabetes test kit? ☐ Yes ☐ No If so, what is your average fasting blood sugar level? __________

Are you currently taking any sleep aid medications? ☐ Yes ☐ No If so, what strengths of the following? _______mg

Sonata Ambien Ambien CR Lunesta BuSpar Vistaril Rozerem Unisom

Are you currently being treated for Restless Leg Syndrome (RLS)? ☐ Yes ☐ No If so, which of the following? _______mg

Lyrica Cymbalta Neurontin

Are you currently taking any antidepressants such as Prozac, Welbutrin, Paxil, and Zoloft? ☐ Yes ☐ No

If so, please list Name of Medication / Strength / Frequency of use:

______________________/________/_____ X (s) per day Every_____ Hrs ______________________/________/_____ X (s) per day Every_____ Hrs

______________________/________/_____ X (s) per day Every_____ Hrs ______________________/________/_____ X (s) per day Every_____ Hrs

(Please Complete Both Sides)

Do you intake alcohol? ☐ Yes ☐ No If so, Type / Frequency?______________/______ X (s) Per Day Per Week Every______ Hrs

Do you intake Caffeine? ☐ Yes ☐ No If so, Type / Frequency?______________/______ X (s) Per Day Per Week Every______ Hrs

Are you taking any Herbal Supplements / Medicines like St. John's Wort? ☐ Yes ☐ No
If so, which ones? ____

Are you a Smoker? ☐ Yes ☐ No How Much Do You Smoke? _____ Pack(s) per Day Week Month

Within the last year:

Have you had any surgeries? ☐ Yes ☐ No If so, how long ago and what for? ____________________________

Have you had migraines ☐ Yes ☐ No Have you had tingling of your fingertips? ☐ Yes ☐ No

Have you had ringing in the ears? ☐ Yes ☐ No Have you had postural problems? ☐ Yes ☐ No

Have you had ear congestion? ☐ Yes ☐ No Have you had occasional neck pains? ☐ Yes ☐ No

Do you see or have you seen a Chiropractor or Physical Therapist (Circle One) in the last year? ☐ Yes ☐ No

If so, what for ___________________________________ and have you ever sustained a motor vehicle accident? ☐ Yes ☐ No

Have you had CAT scans or MRI's? ☐ Yes ☐ No

Have you ever seen an ENT (Ear Nose and Throat Specialist)? ☐ Yes ☐ No

Have you had sinus problems? ☐ Yes ☐ No

Do you consume grapefruit juice, grapefruits, or grapefruit extract? ☐ Yes ☐ No

Are you taking Tagamet? ☐ Yes ☐ No If so, how often? ______________________________________

Do you take Antacids? ☐ Yes ☐ No If so, how often? ______________________________________

Are you taking any Herbal Supplements / Medicines like St. John's Wort? ☐ Yes ☐ No
If so, which ones? ____

Women:

Are you pregnant or POSSIBLY pregnant at this time? ☐ Yes ☐ No

If, so what would be the approximate Due Date _______________ Are you currently nursing? ☐ Yes ☐ No

Are you currently taking birth control pills? ☐ Yes ☐ No If so, what kind? _________________________________

Do you plan or anticipate on being pregnant in the near future? ☐ Yes ☐ No

List any other Over-the-Counter medications, Vitamins, or herbal supplements you are taking (Name / Strength / Frequency):

______________________/_______/_____ X (s) per day Every_____ Hrs ______________________/_______/_____ X (s) per day Every_____ Hrs

______________________/_______/_____ X (s) per day Every_____ Hrs ______________________/_______/_____ X (s) per day Every_____ Hrs

I have read and answered the above questions to the best of my knowledge. I understand that it is my responsibility to notify Nu Smile and its doctors of any changes in my health history, medical test results, and / or medications. I acknowledge this and understand this may significantly affect the final outcome of my dental treatment result, potential side effects of "drug to drug" interactions and / or my health and / or medical condition(s.

_________________________ _________________ _________________________

Signature of Guest or Parent if minor *Date* *Signature of Doctor*