Daniel B. Levitt, DDS

Patient Medical Update **

Name:_____ **SS#**_____

Address: _____ **Birthdate**_____

Phone:(*Home*)_____(*Work*)_____(*Cell*)_____

Physician _____ *Office Phone* _____ *Date of Last Exam* _____

	Yes	No
1. *Are you under medical treatment now?*	☐	☐
2. *Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?*	☐	☐
If yes, please explain _____		
3. *Are you taking any medication(s) including non-prescription medicine?*	☐	☐
If yes, what medication(s) are you taking? _____		
4. *Have you ever taken Fen-Phen/Redux?*	☐	☐
5. *Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?*	☐	☐
6. *Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?*	☐	☐
7. *Do you use tobacco?*	☐	☐
8. *Do you use controlled substances?*	☐	☐

	Yes	No
10. *Are you wearing contact lenses?*	☐	☐
11. *Are you allergic to or have you had any reactions to the following?*		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. *Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?*	☐	☐
13. *Women Only:*		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	*Heart Disease*	☐	☐	*Chest Pains*	☐	☐
Heart Attach	☐	☐	*Cardiac Pacemaker*	☐	☐	*Easily Winded*	☐	☐
Rheumatic Fever	☐	☐	*Heart Murmur*	☐	☐	*Stroke*	☐	☐
Swollen Ankles	☐	☐	*Angina*	☐	☐	*Hay Fever / Allergies*	☐	☐
Fainting / Seizures	☐	☐	*Frequently Tired*	☐	☐	*Tuberculosis*	☐	☐
Asthma	☐	☐	*Anemia*	☐	☐	*Radiation Therapy*	☐	☐
Low Blood Pressure	☐	☐	*Emphysema*	☐	☐	*Glaucoma*	☐	☐
Epilepsy / Convulsions	☐	☐	*Cancer*	☐	☐	*Recent Weight Loss*	☐	☐
Leukemia	☐	☐	*Arthritis*	☐	☐	*Liver Disease*	☐	☐
Diabetes	☐	☐	*Joint Replacement or Implant*	☐	☐	*Heart Trouble*	☐	☐
Kidney Diseases	☐	☐	*Hepatitis / Jaundice*	☐	☐	*Respiratory Problems*	☐	☐
AIDS or HIV Infection	☐	☐	*Sexually Transmitted Disease*	☐	☐	*Mitral Valve Prolapse*	☐	☐
Thyroid Problem	☐	☐	*Stomach Troubles / Ulcers*	☐	☐	*Other* _____	☐	☐

MEDICATIONS:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize and request my insurance company to pay directly to the destist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature:_____ **Date:**_____